Medicare Annual Report

Fiscal Year 1979

U.S. Department of Health and Human Services
Health Care Financing Administration

THIRTEENTH ANNUAL REPORT
ON MEDICARE
COVERING FISCAL YEAR 1979

Pursuant to Sec. 1875(b) of the Social Security Act,
as amended (42 U.S.C. 1395(b))

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EXECUTIVE SUMMARY

This Annual Report describes the performance of Medicare in its thirteenth year.

PROGRAM OPERATIONS

During FY 79, the central administration of Medicare and Medicaid was integrated under the Health Care Financing Administration (HCFA). This integration was designed to avoid duplication and to improve consistency in administering these government-funded health programs.

Beneficiaries - As of January 1, 1979, 24.6 million aged and 2.9 disabled people under 65 (a total of 27.5 million) or 12 per cent of the U.S. civilian population were covered by one or both parts of Medicare. The number of aged persons entitled to Medicare protection as of January 1979 increased by 600,000 over the January 1978 enrollment.

Health Care Resources - At the end of June 1979, there were 6,801 hospitals participating in Medicare, with 1,147,498 beds. There were 4,963 skilled nursing facilities, 2,788 home health agencies, 3,373 independent laboratories, and 922 facilities providing maintenance dialysis or kidney transplant services. Additionally, by June 30, 1979, 316 rural health clinics had been certified to participate in the Medicare and Medicaid programs.

Benefit Payments - During FY 79, Medicare paid $19.9 billion in benefits under hospital insurance (Part A) and $8.3 billion for medical insurance (Part B). These amounts represent an increase of 16 per cent over FY 78 payments. Inpatient hospital care accounted for 96 per cent of all Part A payments. Medical insurance payments were predominantly for physicians' services, accounting for 71 per cent of Part B payments.

Claims Processing Performance - Claims received by Part A intermediaries increased to 37.9 million in FY 79, an increase of 3.6 per cent over 1978 experience. Claims received by carriers rose at a rate of 11.5 per cent, totaling 136.2 million in 1979. The average processing time for intermediaries increased from 10.3 days to 10.6 days. The average monthly percentage of bills pending over 30 days dropped from 17.5 per cent to 16.9 per cent. Carriers showed a slight increase in yearly average claim processing time from 13.0 days to 13.2 days. The average monthly percentage of claims pending over 30 days increased from 13.8 per cent to 14.8 per cent.

Contractor Administrative Cost Experience - The FY 79 intermediary workload increased 4.4 per cent over FY 78, whereas, the total cost increased 5.4 per cent. Person years decreased by 3.1 per cent in 1979 which indicates an almost 7.8 per cent increase in productivity per person year.

For carriers, the workload increase was 10.8 per cent with an 8.9 per cent increase in total costs. The unit cost decreased by $.05 during FY 79.

Program Funding - The primary source of hospital insurance financing (91 per cent) is derived from contributions based on earnings by workers, employers and self-employed individuals. The remaining 9 per cent is derived from general revenues and other sources. Supplementary medical insurance (Part B) is financed by three sources of revenue to the Federal Supplementary Medical Insurance Trust Fund: (1) premium payments from enrollees; (2) contributions from general revenues, and (3) interest on fund accumulation.

PROGRAM ADMINISTRATION

Administrative Structure - The overall responsibility for administration of Medicare is vested by law in the Secretary of Health, Education, and Welfare. Within DHEW, primary responsibility for administering the Medicare program is assigned to the Health Care Financing Administration (HCFA). The Social Security Administration is involved in the enrollment of beneficiaries in the program and the maintenance of beneficiary rolls. The Department's Public Health Service acts as a valuable resource in the professional health aspects of the Medicare program. Additionally, the Office for Civil Rights ensures that participating providers are in compliance with the provisions of Title VI of the Civil Rights Act of 1964. The Secretary also uses the services of appropriate State or local health agencies to determine whether providers of service and independent laboratories meet the conditions for participation in the Medicare program. Lastly, intermediaries (Part A) and carriers (Part B) contract with the Federal government to reimburse providers for services rendered. They also provide other services, in accordance with their agreements.

Intermediary and Carrier Performance - Within general guidelines issued by the Health Care Financing Administration, the intermediaries and carriers must develop effective administrative mechanisms for achieving required program results. In FY 79, the performance of Medicare contractors was monitored by HCFA's ten regional offices through the Contractor Inspection and Evaluation Program (CIEP). Onsite reviews and other evaluative techniques were used to assess contractor compliance with functional requirements. These reviews culminated in an Annual Contractor Evaluation Report (ACER) for each contractor.

In 1979, three Part A intermediaries and two Part B carriers (including one carryover from the previous year) were identified as poor performers. The automatic renewal provisions were deleted from their FY 80 contracts.

During FY 79, in the area of evaluation of Part A contractor performance, criteria for measuring performance in the areas of (1) bill processing, (2) provider reimbursement, (3) beneficiary services, (4) fiscal management, and (5) general administration were established. Other standards for unit cost were established. These criteria and standards are being applied in the process of evaluating contractor performance, effective October 1, 1979. Development of similar criteria and standards applicable to Part B carriers will be completed in FY 80.

Contracting Initiatives - Under Section 222 of P.L. 92-603, HCFA was granted experimental authority to test incentive contracting for intermediary and carrier administrative functions. Under an incentive contract, intermediaries and carriers are reimbursed on other than a cost related basis, rather than on the basis of actual costs incurred.

By FY 78, four experimental contract forms had been awarded for the Maryland, Maine, Illinois, and upstate New York carrier service areas. The Maryland Blue Shield contract was the first incentive-type reimbursement contract between HCFA and one of its Part B contractors. The contract was for a 2-year period (calendar years 1977 and 1978). Maryland Blue Shield realized net earnings in the first year of $274,161, which included a reduction in payments for failure to satisfy one of the performance requirements in the agreement. The second operational year (calendar 1978) of the contract had a negotiated fixed rate 8.1 per cent below that which was negotiated in the first year of the contract. During 1978, the contractor sustained a net loss of $74,597, thus realizing a net gain over actual incurred costs of $199,564, or 2.64 per cent, for the 2 years.

In Maine, the Union Mutual Life Insurance Company decided not to renew its contract as the Medicare Part B carrier. Through competitive selection, Blue Shield of Massachusetts (BSM) was chosen to replace Union Mutual. The fixed-price contract was from December 1977 through September 1980. The projected savings resulting from this experimental contract are $772,600.

The HCFA experimental fixed-price contract in Illinois is intended to test the effect of merging carrier service areas and the cost benefit effects of price competition in medium claims volume service areas. The operational period of the contract is April 1979 to September 1983. The successful offeror was Electronic Data Systems Federal Corp. (EDSF). The projected savings to be realized by this experimental contract are $34,790,200.

In upstate New York, the experimental contract is intended to test the cost benefit effect of merging these carrier services in an aggregate medium claims volume service area. The contract is with Blue Shield of Western New York. The operational period is June 1979 to September 1982. The projected savings is $15,593,300.

The first fixed-price competitive bid contract under Part A was to have been awarded for the State of Missouri on July 2, 1979. Court action against DHEW enjoined them from making an award in the procurement. Among other things, the parties initiating the suit contended that the planned experiment violated existing Medicare legislation regarding nomination of Part A fiscal intermediaries. DHEW has filed an appeal and is awaiting a decision.

Another experimental contract was enjoined in the Colorado, Utah, and Wyoming service area. The issues in the litigation are similar to those in Missouri. Again, DHEW has appealed the District Court decision.

Reimbursement Controls/Policy Initiatives - In FY 79, several initiatives were undertaken to contain program costs without reducing the quality and accessibility of health care services to program beneficiaries. Of significance were:

- Reasonable Cost Limits - Medicare recognized that reimbursement on the basis of incurred costs does not offer sufficient incentives to promote the degree of efficiency and economy necessary to stem the rapid escalation of health care costs. Regulations implementing Section 223 of P.L. 92-603 authorized the establishment of prospective cost limits based on the classification of providers according to appropriate factors such as similarity in size and

economic characteristics. The limits were first applied to hospital costs. Subsequently, limits were developed for home health agency costs and skilled nursing facility costs.

- o Salary-Related Reimbursement of Certain Therapy Services - During FY 79, HCFA continued to work to implement salary equivalency guidelines for physical therapy and respiratory therapy services furnished under arrangements between providers and independent contractors.

- o PSRO review costs - Due to legislative and executive concern regarding the costs of PSRO review, a budgetary limit on the amount of money which could be expended from the trust funds for PSRO hospital review was established. To comply with this limit, HCFA directed PSROs nationwide to reduce costs. Instructions were issued to intermediaries concerning steps they must follow when settling delegated (i.e., when the hospital itself performs review under delegation from PSRO) review costs.

- o Primary Care Intern and Resident Programs - HCFA published a Notice of Proposed Rulemaking which will change current regulations and encourage the development of intern and resident programs in primary care.

- o Home Health Agency Reimbursement Initiatives - HCFA issued further instructions to enable intermediaries to analyze more uniformly the necessity for and reasonableness of home health agency operating costs.

- o Direct Apportionment of Malpractice Costs - A national study indicated that malpractice awards for Medicare patients are significantly lower in amount than awards for non-Medicare patients. During 1979, HCFA published final regulations governing the direct apportionment of malpractice costs to the Medicare program. The purpose is to reimburse Medicare providers on a basis more closely related to actual malpractice experience.

- o Elimination of the Combination Method of Apportionment and Modified Cost Finding for Providers - In early 1979, HCFA published final regulations which eliminated the Combination Method of apportionment and modified cost finding used to determine Medicare reimbursement for health care facilities. The purpose of the regulations is to achieve greater uniformity in determining cost reimbursement under the Medicare program.

- o Reimbursement of the Costs of Blood - During 1979, HCFA began taking steps to monitor more aggressively the application of reimbursement policies when making payment for blood and blood products. In late

summer, 1979, HCFA distributed for comment special instructions which discuss in detail the considerations applicable to reimbursement for blood and blood products. Proposed expanded regulations should follow in FY 80.

- o Laboratory Services and Durable Medical Equipment - An initial list of 2 items of durable medical equipment and 12 most commonly performed laboratory services, to which the lowest charge level limitation applies, was published in the Federal Register on July 26, 1978, along with the final regulation. On January 24, 1979, HCFA published in the Federal Register a proposed notice of laboratory tests commonly paid for by Medicaid, but not Medicare, that would be subject to the lowest charge level limits. Similarly, a proposed notice for the Medicare and Medicaid programs was published in the Federal Register on March 26, 1979. The notice identified 15 additional laboratory services and 5 additional items of durable medical equipment as falling within the scope of the regulation.

Improving Utilization Safeguards - One of the most critical areas of Medicare program activity is to establish safeguards against improper and excessive utilization of health care services. The program has approached its responsibilities in this area in a number of ways. The structure of the program provides some fundamental controls. For example:

- o benefit limits on number of days of care in hospitals and extended care facilities and home health visits.
- o deductible and coinsurance amounts.
- o services must be furnished on a physician's order or under direction of a physician.
- o inpatient services must be certified by a physician or PSRO as medically necessary.
- o services must be reasonable and necessary for the diagnosis and treatment.

HCFA has continued to refine the pre and postpayment screens which intermediaries and carriers utilize to identify situations of potential overutilization or variations from medical necessity norms. Additionally, HCFA is continuing an intensive study of medical necessity criteria presently applicable within the Medicare program.

Quality and Appropriateness of Care - HCFA must assure that facilities caring for Medicare beneficiaries are structurally safe, clean, properly staffed, and provide needed services. Additionally, HCFA must assure that the actual care delivered to beneficiaries is of high quality. HCFA must also make sure that services are necessary and performed at the most economical level consistent with good care. Several interrelated quality assurance programs are in place to fulfill HCFA's responsibilities in this area.

- o Standards and Certification - Facilities providing health care services to Medicare beneficiaries must meet certain health and safety standards before they can receive Medicare reimbursement. Annual surveys are conducted by States, under contract with the Department. However, in accordance with the Social Security Act, hospitals accredited by the Joint Commission on Accreditation of Hospitals are deemed to meet most of the requirements for Medicare participation. The Secretary is required to perform surveys to verify that the acceptance of JCAH accreditation is an effective means of assuring the absence of serious deficiencies in participating accredited hospitals.

  Generally, the Federal Standards and Certification program is responsible for establishing and updating Federal health care standards, developing State survey procedures, and monitoring surveys and enforcement. This report includes discussions of major FY 79 activities in the following areas:

  Skilled Nursing Facility/Intermediate Care Facility Conditions of Participation

  Hospital Conditions of Participation

  Survey and Certification Procedures (Subpart S)

  Fire Safety Evaluation System

  End-Stage Renal Disease Minimum Utilization Rates

  State Agency Evaluation Procedures

  JCAH Validation Process

Professional Standards Review Organizations - The PSROs are responsible for assuring the quality of actual patient care practices in facilities that have been certified as meeting Federal health and safety standards. PSROs are required to review health care services delivered in hospitals and long-term care facilities and eventually, may expand their review system to cover ambulatory care. There are 195 designated PSRO areas nationwide. At the end of FY 79, PSRO review had been implemented or initiated in 187 of these areas. Planning contracts exist in an additional three areas. Five PSRO areas are currently unfunded.

The evaluation of the Professional Standards Review Organization, (covering calendar year 1978) is the third in a series. The evaluation reveals that for the second consecutive year, PSROs have reduced Medicare hospital utilization relative to inactive PSRO areas, and the PSRO Medicare concurrent review activity continues to pay for itself. PSROs showed a 1.1 benefit-cost ratio for 1977, and in 1978 analysis disclosed a 1.269 ratio.

End-Stage Renal Disease Medical Review Boards - ESRD/MRBs have quality assurance functions similar to PSROs. However, they review a special Medicare population over a much larger geographic area: the ESRD area. There are 32 designated network areas. During FY 79, the first full year of operation for some MRBs, most Boards were engaged in conducting medical care evaluation studies. The topics of the reviews varied according to local needs. In order to assist MRBs carry out their review responsibilities more effectively, HCFA funded a contract in FY 79 to develop technical guidance for MRBs.

Second Surgical Opinion Program - In FY 78, HCFA began a major consumer information campaign to encourage all Americans to seek a second opinion before undergoing non-emergency surgery. In 1978, nearly 4 million brochures regarding a second opinion were distributed throughout the United States. In July 1979, a message encouraging Social Security beneficiaries to seek second opinions was enclosed with the beneficiary check. During FY 79, approximately 13,500 calls were made to a National Hotline and about 7,400 calls were made to local referral centers. In addition, HCFA funded two demonstration projects (discussed in detail in Chapter III) to provide free second opinion (and third opinion) resources for over 2 million Medicare beneficiaries.

Increasing HMO Enrollment by Medicare Beneficiaries - Essentially, HMOs combine the major components of health care delivery in a single organizational structure, either by (1) directly employing or owning the necessary personnel and facilities or by (2) purchasing, or otherwise arranging for, the covered services. The entire range of services is purchasable by HMO members through a regular premium payment, which insures the member against the costs of any care furnished through the HMO.

By the end of 1978, there were approximately 23 HMOs under Medicare contract. As of December 31, 1979 there were approximately 42,000 Medicare enrollees and 31 HMO Medicare contracts.

Fraud and Abuse Control Activities - The Health Care Financing Administration is responsible for activities to control fraud and abuse in the Medicare program. In carrying out its responsibilities, HCFA cleared 27,478 integrity reviews, 2,877 full-scale abuse reviews, and 526 full-scale fraud reviews in FY 79. Additionally, 216 cases were referred to the Office of Investigations.

In FY 79, action was taken to suspend (under Section 1862(e) of the Act) 46 physicians/practitioners from participation in the Medicare program. These suspensions resulted from their conviction of a criminal offense related to their involvement in the Medicare or Medicaid program.

During 1979, approximately 3,500 PARE (payment reviews) reviews were completed. These reviews disclosed a projected overpayment of $2.9 million, resulting in the initiation of recoupment actions by Medicare carriers.

During FY 79, HCFA intensified its validation review program. These efforts identified a potential of over $9.5 million in overpayments or program savings. Other fraud and abuse activities identified:

- Medicare overpayments totaling $9.3 million (including $2.5 million of the $9.5 million identified in program validation reviews).
- Savings from systems and procedural changes totaling almost $1.2 million.
- Projected deterrent value of $6.2 million.

Beneficiary Services - In order to create a high-level focus for beneficiary service improvement within HCFA, the Office of Beneficiary Services was established. Major involvements during FY 79 include:

- At the end of FY 79, toll free telephone service had been established, either partially or completely, at all carrier locations. This service will provide beneficiaries with immediate access to carriers, who have access to the claims records. Therefore, carriers can provide more prompt answers to beneficiary questions.
- HCFA continued to expand beneficiary aide programs. Forty-three programs have been developed in various parts of the country, in collaboration with the National Council of Senior Citizens.
- In collaboration with the National Association of Insurance Commissioners, a pamphlet "Guide to Health Insurance for People with Medicare" was issued in September, 1979. It offers a number of guides to help beneficiaries make judicious choices and avoid unscrupulous "Medi-Gap" marketing practices by some insurers.

REPORT ON EXPERIMENTS AND DEMONSTRATION PROJECTS

Research and experimentation in support of the Medicare program is authorized under the Social Security Act Amendments of 1965, 1967, 1972, and 1977 and under the National Health Planning and Resources Development Act of 1974. The Health Care Financing Administration studies and develops ways to promote efficiency and quality within Medicare and other HCFA programs. HCFA assesses the impact of its programs on health care costs, program expenditures, beneficiary access to services, health care providers, and the health care industry. Research and demonstrations conducted by HCFA test and evaluate alternatives to present reimbursement, coverage, eligibility, and management policies of the current Federal programs.

In FY 79, HCFA conducted research and demonstration projects in the following ten program areas:

1. Beneficiary Impact
2. Fraud and Abuse
3. Health Systems Organization
4. Hospital Costs
5. Industrial Organization
6. Integrated Data Systems
7. Long Term Care
8. Physician Reimbursement
9. Program Evaluation
10. Quality and Effectiveness

A detailed discussion of each project is contained in Chapter III of this report.

INTRODUCTION

This Annual Report describes the performance of Medicare in its thirteenth year - from October 1, 1978 through September 30, 1979.

Fiscal Year 1979 was filled with new challenges for all government programs, especially publicly funded health programs. One challenge has been to manage the growing health care needs in an era of limits: limited resources, limited funds, and limited patience on the part of the American people who expect more for their tax dollar. A second challenge has been inflation. Health care inflation leads the Consumer Price Index, particularly hospital cost inflation. If hospital costs continue to double every 5 years, the government's ability to purchase the kind of quality care Medicare and Medicaid beneficiaries deserve will be exceeded.

In order to better confront these and other challenges in FY 79, significant changes occurred in the administration of Medicare. The central administration of Medicare and Medicaid was integrated under the Health Care Financing Administration (HCFA), effective June 20, 1979. HCFA's reorganized structure provides for more effective administration of Medicare and Medicaid by aligning HCFA's organizational units more consistently with the key functions HCFA must perform. The integration of Medicare and Medicaid permits simplification and greater consistency of administrative procedures between the two programs. The new organizational structure is designed to accomplish HCFA's primary mission; i.e., promoting the delivery of appropriate, high quality health care service to eligible individuals on a timely and cost effective basis.

This report describes HCFA's continuing efforts in the Medicare program to improve program efficiency, reduce program administrative costs, reduce paper work burdens, combat inflation in health care costs, improve the quality of health care services, and minimize inappropriate expenditures. Underlying these efforts is a special commitment to serve the Medicare beneficiary (the aged and disabled) -- the segment of the population most in need of health care services. We believe this report reflects progress toward HCFA's goals and documents the creative efforts which occurred in the Medicare program during FY 79 to manage resources wisely, in the best interests of those being served.

CHAPTER I. PROGRAM OPERATIONS

A. BENEFICIARIES

As of January 1, 1979, 24.6 million aged and 2.9 million disabled people under 65 (a total of 27.5 million) or 12 per cent of the U.S. civilian population were covered by one or both parts of Medicare. Of that number, 27.1 million had hospital insurance protection (Part A), and 26.4 million had enrolled in the voluntary medical insurance program (Part B). Of beneficiaries over age 65, 95 per cent were covered by both Part A and Part B; 92 per cent of disabled beneficiaries were covered by both parts.

The number of aged persons entitled to Medicare protection as of January 1979 increased by 600,000 over the January 1978 enrollment. This increase reflects the continuing trend of the last decade in an annual net growth of over 2 per cent in the over-65 segment of the U.S. population. In addition to this growth in the number of aged, the average age is also increasing. There has been a 12 per cent decline over this 10-year period in the death rate of the 65 and older group. These factors contribute to more intensive use of Medicare-covered health care services over a longer period of time.

B. HEALTH CARE RESOURCES

At the end of June 1979, there were 6,801 hospitals participating in Medicare, with 1,147,498 beds. Included in the participating hospitals were 6,128 short stay hospitals, 411 psychiatric, and 262 other long stay institutions. Eighty-six per cent of the total number of beds are in short stay hospitals, 12 per cent in psychiatric institutions, and 2 per cent in other long stay institutions. It is estimated that over 95 per cent of all short stay acute care hospital beds in the country are Medicare certified.

As of June 30, 1979, there were 4,963 skilled nursing facilities with 419,835 beds participating in Medicare. Participating facilities include skilled nursing facilities, separately organized extended care units in hospitals, and some separate skilled nursing units connected with residential homes for the aged. In December 1979, only 320 of the total number of skilled nursing facilities were hospital based.

The number of home health agencies participating in the Medicare program rose from 2,605 to 2,788 in the 12-month period ending June 30, 1979.

At the end of June 1979, a total of 3,373 independent laboratories had been approved for Medicare reimbursement. There are 21 reimbursable categories of clinical tests or procedures. Laboratories can be reimbursed by Medicare only for those tests which they are certified to perform.

Under the renal disease program, 922 facilities provided services to program beneficiaries requiring maintenance dialysis or kidney transplant. Of the total number of participating providers, in June 1979, 137 hospitals were certified as both Renal Transplant Centers and Renal Dialysis Centers, providing both transplant surgery and dialysis services. Eight hospitals were approved as Renal Transplant Centers only. An additional 471 hospitals were

certified as Renal Dialysis Centers only, providing the full spectrum of diagnostic, therapeutic and rehabilitative services required for the care of dialysis patients. The remaining 306 facilities were certified as free standing dialysis-only facilities.

A new category of health care facility was added by the Rural Health Services Clinic Act of 1977 (P.L. 95-210). Congress enacted this legislation in recognition of the fact that the only type of primary and emergency care services available to residents of isolated rural communities could not be covered under the Medicare program because the services were not provided by a physician. The law authorizes Medicare (and Medicaid) payments to qualified rural health clinics. Payments are for covered health care services furnished to program beneficiaries by or under the direction of a physician assistant or nurse practitioner, even if the clinic is not under the full-time direction of a physician. By June 30, 1979, 316 rural health clinics had been certified to participate in the programs.

C. BENEFIT PAYMENTS

During FY 79, Medicare paid $19.9 billion in benefits under hospital insurance (Part A) and $8.3 billion under medical insurance (Part B). These amounts represent an increase of 16 per cent over FY 78 payments of $17.4 billion and $6.9 billion respectively. Almost half of the amount of the increase resulted from increases in hospital costs and higher physician fees recognized by the program. The remainder of the increases were due to such factors as utilization of more expensive technology in health care delivery, increasing rates of utilization of services, and increases in both the number of aged beneficiaries and the proportion of persons aged 75 or older within the aged population. The latter group require more medical services and more frequent hospitalization for longer periods of stay.

Inpatient hospital care accounted for 96 per cent of all Part A payments. Although the program covers convalescent care after a hospital stay of at least 3 days, either by direct transfer to a skilled nursing facility or through home health services, these alternatives to expensive hospital care have not been as successful as originally hoped. Benefit payments for these two levels of extended care services represented only 4 per cent of total Part A payments.

Medical insurance payments were predominantly for physicians' services, accounting for 71 per cent of Part B payments. The next most significant reimbursed item was for outpatient hospital services (19 per cent), followed by home health services (2 per cent) and laboratory and other services (8 per cent).

Inpatient Hospital Services

For the 12-month period ending December 1978, there were approximately 9.6 million hospital admissions. Admissions of the aged accounted for 88 per cent of the total, while the remaining 12 per cent were for the disabled. The admissions rate per 1,000 enrollees was 346 for the aged and 396 for the disabled. In FY 79, hospitals were paid $19.1 billion for Part A benefits, 96 per cent of all Part A payments.

Skilled Nursing Facility Services

Admissions to skilled nursing facilities for the 12-month period ending December 1978 totaled approximately 507,600 (490,000 aged and 17,600 disabled). This represents an annual admission rate of 21 per 1,000 aged beneficiaries and 6 per 1,000 disabled beneficiaries. Reimbursement totaled approximately $368 million, or 1.8 per cent of total Part A payments in FY 79.

Home Health Services

Over 17 million visits were provided by home health agency personnel during the 12-month period ending December 1978, an average of 629 visits per 1,000 beneficiaries. Home health service benefit payments under both hospital and medical insurance totaled $634 million for the 12 months ending September 30, 1979, 2 per cent of total Medicare benefit payments.

Physician Services

For FY 79, medical insurance payment for physicians' services totaled approximately $5.8 billion, about 71 per cent of total Part B payments.

Other Medical Services and Supplies

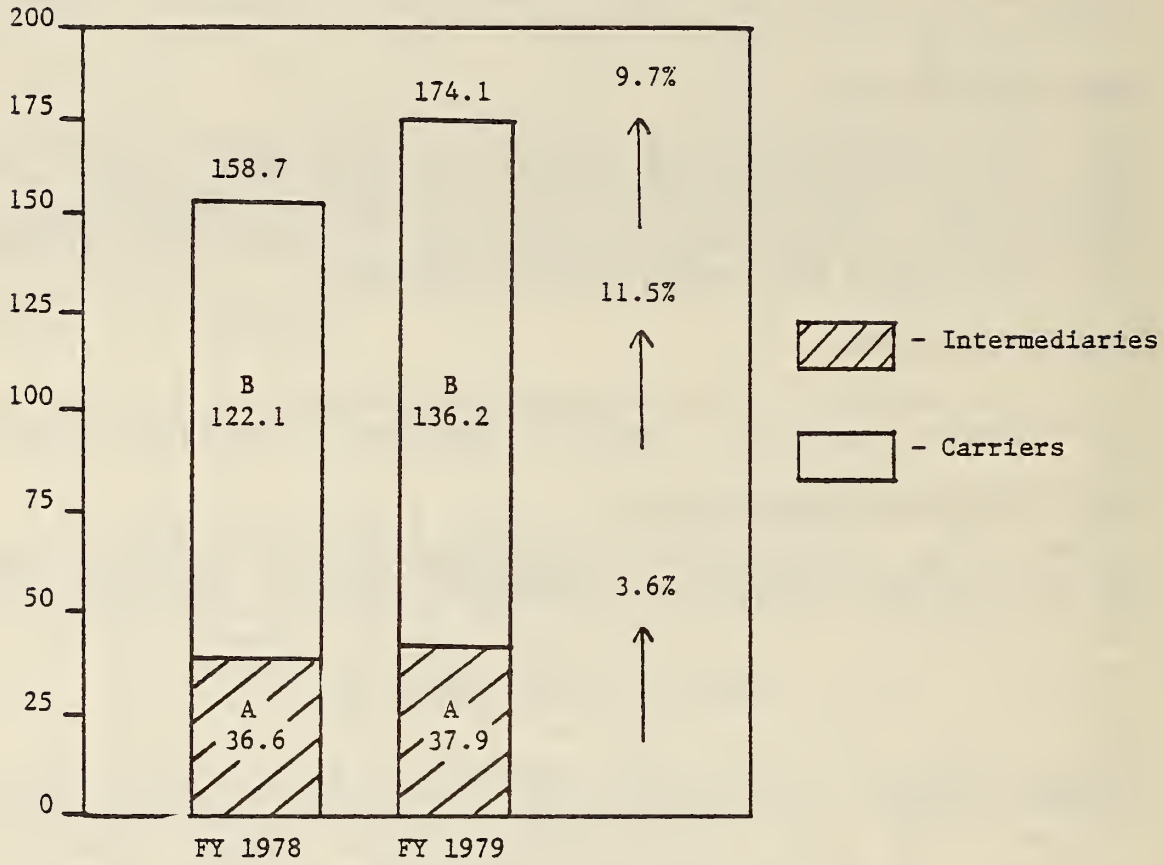
For FY 79, approximately $1.6 billion was paid for outpatient hospital services and $673 million for independent laboratory and other services.

D. CLAIMS PROCESSING PERFORMANCE

Claims receipts -- The volume of Medicare claims received continued to increase through FY 79. Contributing to this upward trend were the steady increase in the number of covered beneficiaries, increased utilization of covered services, and the tendency of beneficiaries to submit claims for each bill or service received rather than accumulating them for periodic submittal. Claims received by Part A intermediaries increased to 37.9 million in FY 79, an increase of 3.6 per cent over 1978 experience. Claims received by carriers rose at a rate of 11.5 per cent, totaling 136.2 million in 1979. Overall, the volume of Medicare claims rose 9.7 per cent.

Claims Received by Medicare Contractors

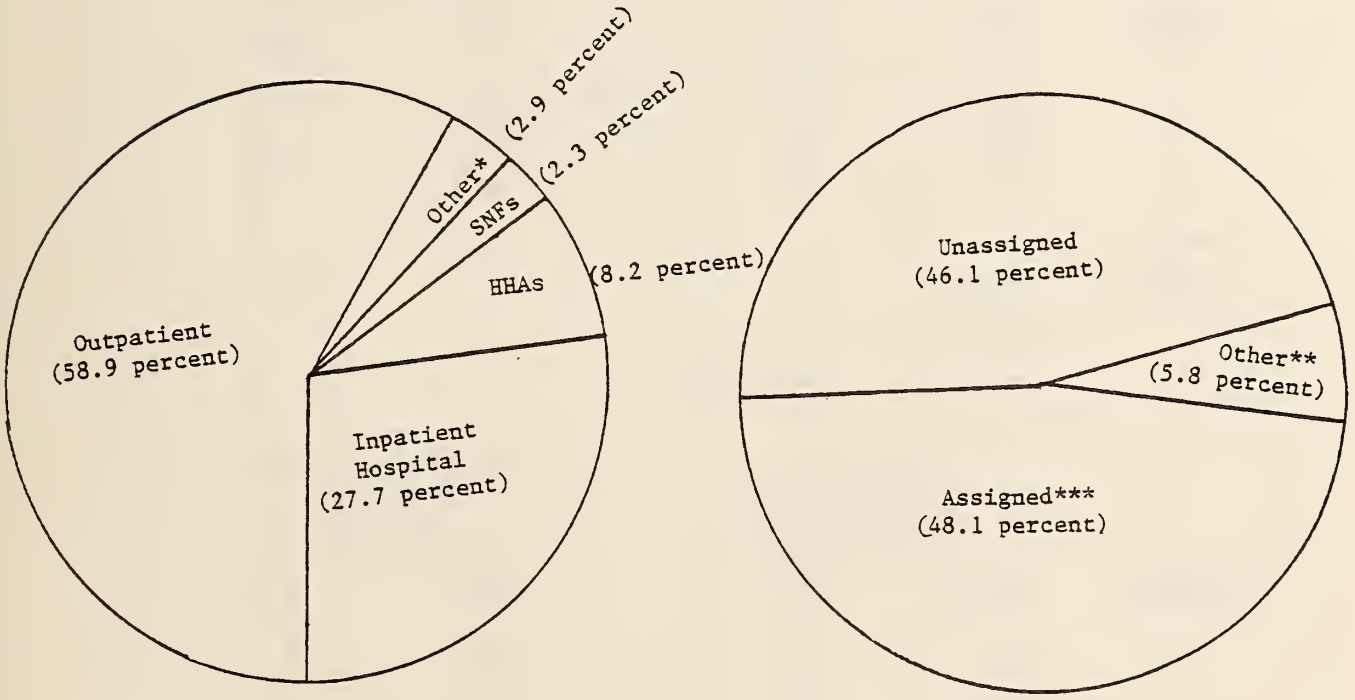
(millions)



Distribution of Claims -- The majority of claims received by intermediaries during FY 79 represented requests for payment for outpatient services provided to Medicare beneficiaries. These claims accounted for 58.9 per cent of the total received by intermediaries. Inpatient hospital claims accounted for 27.7 per cent of the receipts while claims for home health agency and skilled nursing facility services represented 8.2 per cent and 2.3 per cent, respectively. The remaining 2.9 per cent were claims submitted for ancillary and other miscellaneous services payable under Part B.

Claims received by carriers during FY 79 were nearly equally divided between those submitted by physicians and suppliers on assignment (48.1 per cent) and those submitted by unassigned beneficiaries (46.1 per cent). The remaining claims (5.8 per cent) were those submitted by provider-based physicians and group practice prepayment plans. In comparision to 1978 experience the per cent of assigned claims to total claims showed a slight increase of 0.9 percentage points.

Distribution of FY 79 Receipts by Type of Claim



* Ancillary and other miscellaneous services payable under Part B.

** Claims for services provided by provider-based physicians and group practice prepayment plans, who do not bill patients directly.

*** This represents the assignment rate measured against all claims. When measured only against claims in which patients are billed directly, i.e., excluding the 5.8 per cent of claims for provider-based physician services and group practice prepayment plan services, the assignment rate in FY 79 was 51.1 per cent, the figure usually quoted as the Medicare assignment rate.

Claims processing timeliness -- Timeliness measures of contractor claims processing performance in FY 79 indicated only a slight increase for both intermediaries and Part B carriers, compared to FY 78 experience. The average processing time for intermediaries increased from 10.3 days to 10.6 days, while the average monthly percentage of bills pending over 30 days dropped from 17.5 per cent to 16.9 per cent. Carriers showed a slight increase in yearly average claim processing time from 13.0 days to 13.2 days. Over the same time period the average monthly percentage of claims pending over 30 days for carriers increased from 13.8 per cent to 14.8 per cent.

Intermediaries

	Contractor Processing Time (Mean Days)		Per Cent of Claims Pending Over 30 Days	
Quarter	1978	1979	1978	1979
1	9.8	10.9	18.2	19.8
2	10.3	11.1	18.4	17.1
3	10.2	10.1	16.9	16.2
4	10.7	10.2	16.5	14.3
Yearly Average	10.3	10.6	17.5	16.9

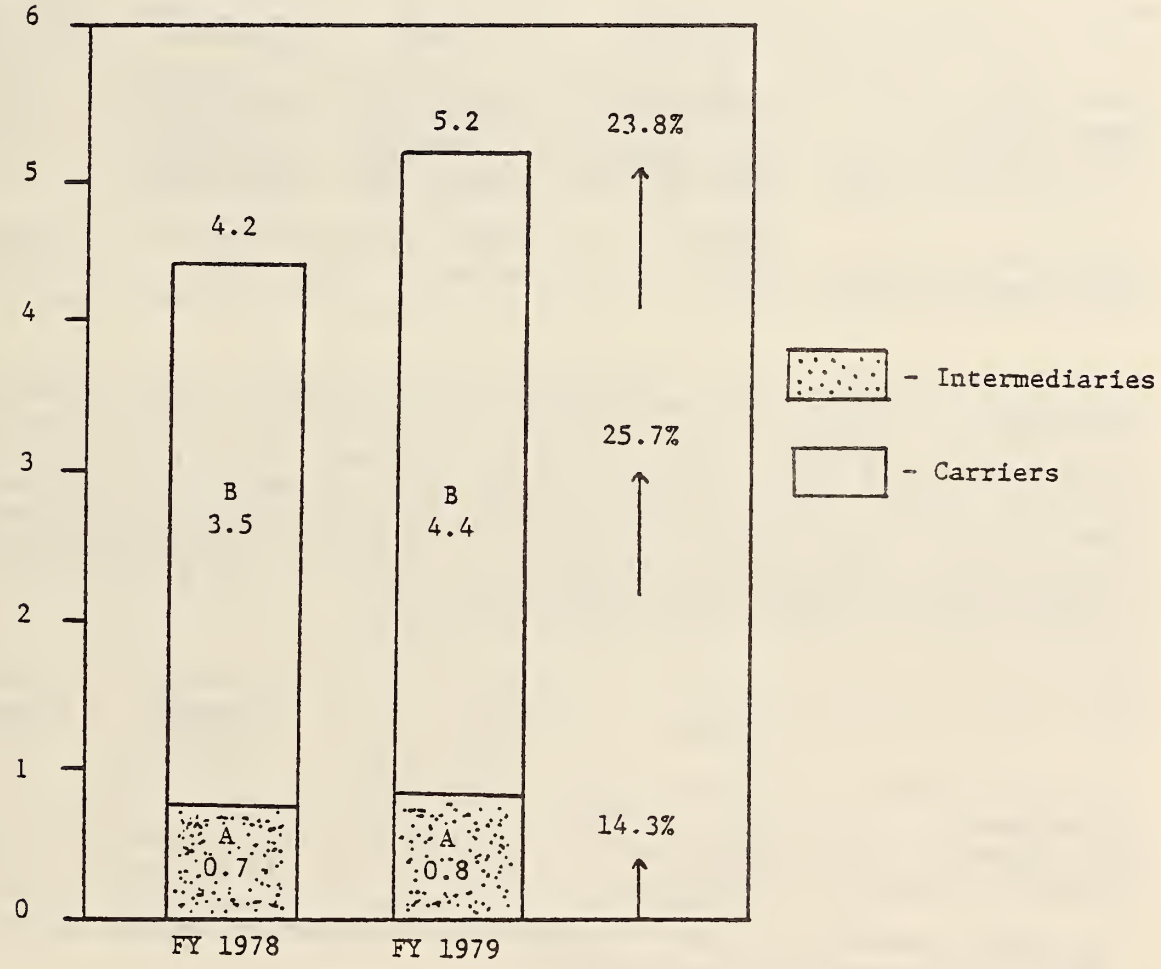
Carriers

	Contractor Processing Time (Mean Days)		Per Cent of Claims Pending Over 30 Days	
Quarter	1978	1979	1978	1979
1	12.1	12.9	13.8	14.5
2	14.7	15.8	15.2	17.6
3	12.6	12.0	12.4	13.2
4	12.4	11.9	14.0	13.4
Yearly Average	13.0	13.2	13.8	14.8

Claims pending -- Both intermediaries and carriers experienced increases in the volume of their pending claims in FY 79 as compared to FY 78. Intermediaries showed a 14.3 per cent increase in pending claims to 0.8 million, and Part B carriers' pending claims rose by 25.7 per cent to 4.4 million.

Claims Pending for Medicare Contractors

(millions)



E. CONTRACTOR ADMINISTRATIVE COST EXPERIENCE

Intermediaries -- The FY 79 intermediary workload increased 4.4 per cent over FY 78, whereas the total cost increased 5.4 per cent. Person years decreased by 3.1 per cent in 1979 which, in view of the higher workload, resulted in an almost 7.8 per cent increase in productivity per person year.

The unit cost for all operations increased 5 cents reflecting the 9 per cent increase in audit costs. On the other hand, the unit cost for all operations excluding audit costs decreased by 1 cent.

	FY 78	FY 79	Net Change Increase (Decrease)	Per Cent Change Increase (Decrease)
Workload	34,862,400	36,410,100	1,547,700	4.4
Total Cost	$191,259,700	$201,546,200	$10,286,500	5.4
Provider Audit	47,695,400	51,980,900	4,285,500	9.0
Total Cost (Ex.Audit)	$143,564,300	$149,565,300	$ 6,001,000	4.2
Unit Cost	$5.49	$5.54	$ .05	0.9
Unit Cost (Ex.Audit)	$4.12	$4.11	$(.01)	(0.2)

Carriers -- The unit cost decreased by $.05 during FY 79. This was the net result of the workload increase of 10.8 per cent while total costs increased only 8.9 per cent. Factors which contributed to the lower cost included a 14 per cent increase in productivity per person year, developed in part through the implementation of fixed price contracts. Offsetting this productivity savings were an increase of 7.7 per cent in the Average Personal Service Cost per person year and the $3.7 million implementation/termination costs associated with the experimental contracts.

	FY 78	FY 79	Increase (Decrease)	Increase (Decrease)
Workload (Claims Processed)	120,439,700	133,494,900	13,055,200	10.8
Total Cost	$344,572,700	$375,273,500	$30,700,800	8.9
Unit Cost (Claims)	$2.86	$2.81	$(.05)	(1.7)

Appendix F presents a 5-year trend analysis of contractor administrative cost factors and productivity improvements.

F. PROGRAM FUNDING

Under the Social Security Act, the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund are held by two Boards of Trustees, each comprised of the same three members who serve in an ex officio capacity. The Secretary of the Treasury is designated by law as the managing trustee of both funds. The other members of the Board are the Secretary of Labor and the Secretary of Health, Education, and Welfare. The Administrator of the Health Care Financing Administration serves as Secretary of both Boards. The two Trust Funds were established on July 30, 1965, as separate accounts in the U. S. Treasury to hold the amounts accumulated under the respective programs. The Board of Trustees issues annual reports on the status of the two Trust Funds.

The primary source of hospital insurance financing (91 per cent) is derived from contributions based on earnings by workers, employers and self-employed individuals. The remaining 9 per cent is derived from general revenues for certain uninsured individuals who attained age 65 before 1975, premium income for voluntarily enrolled individuals, transfers from the Railroad Retirement Board, military service credits, Professional Standards Review Organizations, Maternal and Child Health, and interest on accumulated funds.

Supplementary medical insurance (Part B) is financed by three sources of revenue to the Trust Fund: premium payments from enrollees, contributions from general revenues, and interest on fund accumulation.

When the trust fund was initially established in 1966, the Government contribution from general revenues was equal to the premium income collected from beneficiaries under a 50-50 matching formula. Effective in 1973, under a legislative amendment, year-to-year increases in beneficiary premiums were limited to the per cent by which general Social Security benefit levels had increased in the preceding year. Since July 1973, as a result of this provision and because the cost of the Part B program has increased, due to inflation of medical prices, at a rate considerably above the general cost of living adjustment which is applied to Social Security benefit increases, the Government contribution has increased significantly. In FY 79, the Government contributed 70 per cent of program income and the beneficiary contribution was 27 per cent of program income. Three per cent of the income resulted from interest accumulated by the trust fund.

More detailed information about the status of the Hospital Insurance and Supplementary Medical Insurance Trust Funds, showing income, disbursement and future projections are contained in the Annual Reports submitted to the Congress by the Boards of Trustees of the two Funds.

CHAPTER II. PROGRAM ADMINISTRATION

A. SUMMARY OF ADMINISTRATIVE STRUCTURE

The overall responsibility for administration of Medicare is vested by law in the Secretary of Health, Education, and Welfare. The statute also provides for significant participation in certain areas of administration by private organizations and public agencies.

Within the Department of Health, Education, and Welfare, primary responsibility for administering the Medicare program is assigned to the Health Care Financing Administration (HCFA). Special responsibilities in connection with health care standards of Medicare have been assigned to the Public Health Service. The Office for Civil Rights of the Department is responsible for assuring necessary conformance by participating health care facilities with Title VI of the Civil Rights Act of 1964.

Role of the Health Care Financing Administration - The Health Care Financing Administration negotiates and administers agreements with (1) the intermediaries and carriers which perform payment and other program functions, (2) the State agencies which certify health facilities for participation in the program, and (3) hospitals and other institutions which provide services for which the program makes reimbursement. HCFA also develops reimbursement principles and guidelines, participates with the Public Health Service in the formulation of the conditions of participation, formulates Medicare regulations, develops program policy and procedural instructions, and performs the basic recordkeeping and data processing functions required for adminstration of the program. Additionally, HCFA assures the quality, appropriateness and necessity of services for program beneficiaries.

Role of the Social Security Administration (SSA) - With the establishment of HCFA on March 8, 1977, responsibility for Medicare activities was transferred from SSA. However, by agreement, SSA continues to perform some functions. Chief among these are: (1) District Office Services - Applicants for Medicare continue to make applications for Medicare coverage, as well as make inquiries and file appeals to SSA District Offices. SSA District Office staff also respond to inquiries regarding Medicare, process beneficiary appeals, explain Medicare eligibility requirements, make eligibility determinations, obtain required proofs, and issue notices of Medicare eligibility. (2) Medicare Records Functions - SSA is involved with activities relating to Medicare enrollment. Master records are established and maintained by SSA, and they provide information about beneficiary eligibility and utilization of medical services. (3) Appeals Function - Certain appeals functions are handled by SSA. These include provider appeals (Part A) where more than a statutory minimum is at issue, and which may be adjudicated by the Provider Reimbursement Review Board.

Role of the Public Health Service - The Department's Public Health Service (PHS) acts as a valuable resource in the professional health aspects of the Medicare program. PHS participates with the Health Care Financing Administration in formulating the conditions of participation for providers of services, provides assistance to the State agencies in carrying out their Medicare responsibilities, supports and evaluates experimental approaches to utilization review, and provides professional advice in many technical and medical aspects of program administration.

Role of the Office for Civil Rights - Title VI of the Civil Rights Act of 1964 provides that no institution, agency, or activity receiving Federal financial assistance may engage in discriminatory practice on the basis of race, color, or national origin. Thus, before any hospital, skilled nursing facility or home health agency may be a participating provider under Medicare, their compliance with the provisions of Title VI must be assured. The Office for Civil Rights is responsible for assuring compliance with Title VI.

Role of the State Agencies - The law requires that, wherever possible, the Secretary use the services of appropriate State or local health agencies or other appropriate State or local agencies in determining whether providers of services and independent laboratories meet the conditions for participation in the Medicare program. All 55 jurisdictions (including the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa) have designated agencies -- in most instances State health agencies -- to perform this function.

In carrying out their responsibilities under the health insurance program, the State agencies conduct field surveys of institutions and agencies to determine the extent to which these facilities meet the applicable conditions of participation. They also undertake periodic resurveys of participating facilities to determine whether they continue to meet such conditions and provide consultative services to facilities experiencing difficulties in meeting the participation requirements. The agencies identify non-participating hospitals which can be reimbursed under the program for emergency services, and coordinate activities under the health insurance program with activities conducted under medical assistance programs. The State agencies are reimbursed for the costs of activities they perform in the program, including related costs of administrative overhead and staff.

Role of the Intermediaries - Participating hospitals, skilled nursing facilities, and home health agencies may either receive program reimbursement through a fiscal intermediary or, if they prefer, receive payment directly from the Government. Virtually all providers have chosen to deal through intermediaries. Under agreements with the Secretary of Health, Education, and Welfare, the intermediary is responsible for determining the reasonable costs of services provided to beneficiaries and for reimbursing providers for these costs on behalf of the program. In addition, the agreements authorize the intermediary to provide consultative services to providers, to make audits of provider records, and perform related functions. All agreements also require that the intermediary must assist providers in establishing and applying safeguards against the unnecessary use of services covered under the program. As of September 30, 1979, nine insurers were operating as fiscal intermediaries on behalf of over 14,000 participating providers. The insurers include the Blue Cross Association (with subcontracts to 67 Blue Cross plans) and eight commercial insurers (appendix A). Two hundred twenty-seven hospitals, 74 skilled nursing facilities, and 427 home health agencies were submitting bills directly to HCFA. In addition, HCFA acted as intermediary for 25 outpatient physical therapy providers, 155 comprehensive health centers, 397 Federal emergency hospitals, 23 hospitals providing services to migrant farm workers, and 7 free-standing End Stage Renal Disease dialysis facilities. HCFA also provided accounting and reimbursement services (but not claims processing services) for 34 Kaiser-Permanente facilities in California.

Role of the Carriers - For making program payments under the medical insurance program, the Secretary is authorized to enter into contracts with organizations already engaged in providing, paying for, or reimbursing the cost of health services under group insurance policies or similar group arrangements in return for premiums or other periodic charges. Applying Federal statutes, regulations and instructions, the selected carriers determine the amounts to be paid to physicians and to suppliers for services rendered under the program and make payments for such services on behalf of the program. Under the terms of their contracts with the Secretary, they are required to assist in the application of safeguards against the unnecessary utilization of services, and to serve as a channel of communication for information relating to the administration of the program.

As of September 30, 1979, there were 29 Blue Shield plans, 12 insurance companies, one data processing company, and one State agency operating as carriers (appendix B).

B. ACHIEVING MORE EFFICIENT INTERMEDIARY AND CARRIER PERFORMANCE

Essentially, beneficiaries and the health community, as well as the public at large, view the performance of Medicare as the performance of intermediaries and carriers. Their effectiveness in processing claims, in communicating program policies and procedures to the public and in establishing relationships with the health community, shapes the public and professional response to the program.

Within general guidelines issued by the Health Care Financing Administration, the intermediaries and carriers must develop effective administrative mechanisms for achieving required program results. This has led to different patterns in the internal administration and operation of the intermediaries and carriers. Much of the success of Medicare, particularly its acceptance by the health community, is attributable to the opportunities presented by such an administrative pattern. Intermediaries and carriers can develop uniquely responsive mechanisms to meet the variable patterns in the Nation's health care system.

Description of the intermediary claims process - Basically, the intermediary claims process involves (1) determining the amount of program reimbursement due to providers for covered services they furnished Medicare beneficiaries, and (2) making periodic payment of those amounts to providers. Two aspects of the intermediary claims process deserve special note. First, program reimbursement to providers is payment for the reasonable costs of furnishing covered services to the aggregate of beneficiaries receiving such services from the provider over a fiscal period (usually the provider's accounting year). It is not payment on behalf of each beneficiary for the covered services he receives as an individual patient. Thus, in the intermediary claims process, the provider, rather than the beneficiary, submits the claim. Each claim, in effect, is a bill record of services rendered, which is accumulated with all other such records from that provider until the end of its accounting period. At that time, a final cost settlement is made for all covered services rendered by the provider in that accounting period. Interim payments, in amounts related to bills submitted by the provider, are made throughout the accounting period, subject to adjustment on the final settlement for that period.

Secondly, there is no continuing relationship between a given intermediary and an individual beneficiary. A relationship is established only when a beneficiary receives services from a provider whose payments are handled by that intermediary. The beneficiary, at some other time, may receive services from a different provider served by a different intermediary. Thus, no single intermediary can maintain a full record of any beneficiary's use of hospital insurance services. In general, a beneficiary's current eligibility for provider services depends upon the extent of his recent utilization of other provider services anywhere in the Nation. Therefore, it is necessary to maintain a master utilization record so that prior utilization information can be made immediately available as needed. A master utilization record was established within the Health Care Financing Administration and intermediaries are linked by wire communications for rapid query of the central records whenever eligibility and deductible status information is required.

The intermediary claims process for hospital insurance claims is summarized as follows: When a Medicare beneficiary is admitted to a participating

hospital or skilled nursing facility, or begins a course of treatment based on a plan of care from a home health agency, the provider sends the intermediary an admission or a start-of-care notice. The intermediary queries the Health Care Financing Administration's central record system for the patient's entitlement and deductible status, and remaining eligibility for benefits. The intermediary then advises the provider of the patient's eligibility for further benefits and his deductible status. Admission and start-of-care notices are sent to the Health Care Financing Administration by teletype or magnetic tape, or by direct magnetic tape to magnetic tape transmission over high-speed wires. Replies can usually be sent to the intermediary on the second working day after a request for eligibility information has been made.

During the course of treatment, or after beneficiaries are discharged from the hospital or skilled nursing facility or complete a course of home health treatments, the provider submits claims to the intermediary. These claims are used to determine the level of interim payment due the provider, subject to final settlement at the end of the accounting period. Utilization data are forwarded to the Health Care Financing Administration to update the central records. Consequently, accurate information can be provided when replying to subsequent notices of admission or starts of home health care. As part of the updating process, explanation of Medicare benefit notices are sent to the beneficiaries to inform them of (1) services for which the program paid, and (2) the inpatient days or home health visits used in the current benefit period.

Description of carrier claims process. - Carriers reimburse reasonable charges on all claims for physicians' services and other covered medical services that are reimbursable on a charge basis. These claims may or may not be accompanied by copies of physicians' or suppliers' bills. If beneficiaries complete the claim form, they attach bills received. Bills are not attached if the claim is completed by a physician or supplier under assignment, or as an assistance to the claimant. Every claim received by the carrier requires two determinations in respect to each distinct service furnished the beneficiary. First, a determination must be made as to whether the service is covered. If the service is covered, a determination must be made as to the reasonable charge for that service. The efficiency of the carrier claims process is, therefore, greatly dependent upon securing detailed intemization of services rendered. Additionally, carriers must maintain accurate and current information concerning independent physician and supplier charge patterns for similar services to other patients in the same locality.

The basic steps in the carrier claims process are briefly summarized as follows: Upon receipt of claims, controls are established to assure proper disposition and to permit location of claims in the event of inquiry. Claims are reviewed for coverage of services and for completeness of information. They are then forwarded for determination of reasonable charges. The bill charges are compared with customary charges of the physician for such services, and with the prevailing charge established in the locality for similar services. Increasingly, this comparision is accomplished through a computer process in order to handle the volume of claims expeditiously and economically.

It should be noted that each carrier receives claims for payment of medical insurance benefits provided by physicians or suppliers located within its geographic area. This continuity of relationship between the carrier and the physicians and suppliers in a geographical area is essential for the establishment and maintenance of customary and prevailing charge data.

As in the hospital insurance program, HCFA maintains a master eligibility and utilization record of all medical insurance enrollees. As an important step in the claims process, carriers must determine current claimant eligibility for benefits and whether the claimant has met the current year deductible. If the carrier has processed claims earlier in the year, its history file may have information regarding the status of the deductible. If not, the carrier queries the HCFA master record by transmitting essential identifying information and the amount of the reasonable charge. The same transmittal facilities available for intermediaries in Part A are used. HCFA, in updating the master record, responds to the query, generally within 24 hours. HCFA verifies eligibility and identifies the amount of the deductible remaining to be satisfied. The carrier then makes the appropriate payment to the physician or supplier if an assignment has been taken or, if not, to the beneficiary. In assignment cases, the explanation is sent to the physician or supplier with a copy to the beneficiary.

Evaluating the Performance of Medicare Contractors. - In FY 79, the performance of Medicare contractors was monitored by HCFA's 10 regional offices through the Contractor Inspection and Evaluation Program (CIEP). Onsite reviews and other evaluative techniques were used throughout the year to assess contractor compliance with functional requirements set out in the Medicare law, regulations, and general instructions in major operating areas such as bill processing and program reimbursement. These reviews culminated in an Annual Contractor Evaluation Report (ACER) for each contractor, which discussed its performance in major functional areas during the evaluation period.

Using information contained in the ACER, in addition to statistical indicators for unit costs, processing times, and Part B error rates, HCFA has routinely ranked contractors based on their overall performance over the last several years. This process has proven to be an effective tool for identifying those contractors who exhibit a pattern of continuing poor performance with little or no improvement.

By using this methodology in 1978, HCFA identified 4 Part A intermediaries and 4 Part B carriers as the poorest performing Medicare contractors. Seven of these contractors were subsequently notified that renewal of their contracts beyond September 30, 1979, was contingent upon indications that they could substantially improve their performance, including the achievement of performance goals which were established by HCFA.

The performance of one carrier was so poor that it was given only a 6-month contract. HCFA later extended its contract for an additional 6-month period based upon a written agreement concerning the carriers' costs and performance during this time.

All but one of these contractors met all the goals set for contract renewal. The improved performance of these contractors resulted in administrative cost savings, improvements in the timeliness and quality of claims processing, and improvements in other areas of contractor operations. The carrier which did not meet all the goals was given a 1-year extension of its contract to demonstrate its ability to improve its performance in the remaining area of deficiency.

In 1979, three new Part A intermediaries and 2 Part B carriers (including one identified from the previous year) were identified as poor performers.

The automatic renewal provisions were deleted from their FY 80 contracts. HCFA hopes to again achieve improved contractor performance through the concentrated efforts of contractor and Government personnel over the coming year.

In the area of evaluation of Part A contractor performance, Public Law 95-142 mandated the development and application of criteria and standards. During FY 79, criteria for measuring performance in the areas of (1) bill processing, (2) provider reimbursement, (3) beneficiary services, (4) fiscal management, and (5) general administration were established. Standards for unit cost of bill processing, timeliness of bill processing and timeliness of provider cost report settlements were also established. These criteria and standards are being applied in the process of evaluating contractor performance, effective October 1, 1979. Development of similar criteria and standards applicable to the performance of Part B carriers was advanced during FY 79 and will be completed in FY 80.

One major function of intermediaries is the audit and settlement of cost reports submitted by providers. The Medicare program's liability for covered services rendered to eligible beneficiaries results from this activity. A national program was developed to assure the quality of performance in the audit and settlement of cost reports by Part A contractors. The development culminated during FY 78. The result was the Cost Report Evaluation Program (CREP), an objective program for evaluating intermediary cost report settlements. During FY 79, the CREP was revised and updated to incorporate the latest changes in Medicare reimbursement principles.

CREP is designed to measure the quality of the intermediaries' actions in reviewing, adjusting and settling hospital cost reports. The measurement of quality covers (1) adherance to policy and procedures necessary for cost report review and settlement, and (2) discovery and appropriate adjustment of errors in the cost report. Additionally, it provides HCFA and the Medicare program with (1) information on significant problem areas in the application of reimbursement principles by intermediaries, (2) identification of the underlying causes of significant errors or problems and suggestions for improvement, and (3) identification of the areas in the regulations, instructions, policies, etc., which are not clear and therefore, may require clarification or revision.

Part A quality assurance is conducted by regional reviewers on a statistically selected sample of cost reports chosen from a universe of cost reports settled in a given period (usually the prior fiscal period). In order to attain the desired effectiveness, the accountants or analysts must be experienced in auditing procedures and have a knowledge of the principles of Medicare reimbursement. The sample is designed to produce a statistically valid appraisal of the performance of the reviews and settlements conducted by each intermediary.

Currently, the hospital CREP is operational. A sample of cost reports is selected for each intermediary, based on the number of hospital cost reports settled by each respective intermediary. The results of the regional examinations of these samples are regularly monitored and classified by central office. The purpose is to report data on a national basis and to modify and update the program. While the monetary recovery through the CREP may only affect a few providers in the sample, the adoption of the correct application of the reimbursement principle in question will be communicated to all providers serviced by the intermediary.

CREP will produce two by-products: (1) An evaluation of provider costs and reporting through the individual sample of cost reports; and (2) cost savings through recovery of overpayments. A major HCFA objective for FY 80 is the publishing of intermediary rankings which evaluates intermediary performance nationwide. The major cost savings from CREP comes from the deterrent effect of the reviews. However, by-product savings alone produce an estimated 7:1 cost benefit ratio.

Future plans call for the introduction of a Home Health Agency CREP, unaudited hospital CREP, and a Medicare-Medicaid hospital CREP. In FY 80, Medicare intermediaries will approve provider costs of about $21 billion; the figure for Medicaid State agencies is $17 billion. Consequently, the CREP reviews focus on a significant percentage of program expenditures.

The Health Care Financing Administration also maintains a formal carrier quality assurance program. The primary purpose of the program is to provide a statistically valid and objective procedure for evaluating Part B contractors' performances in the quality of claims processing. Each carrier's claims processing operation is evaluated to determine the number and type of claims processing errors. Carriers determine the number and type of claims processing errors. Carriers' claims processing performances are then compared on a national basis through consolidated rankings.

A quarterly report is published which ranks the carriers based on the cumulative error rates assessed during the most recent 12-month period. Carriers are ranked both on occurrence error rate (processing errors per 100 line items in the universe) and on payment/deductible error rate (dollar errors per 100 dollars of submitted charges in the universe). A penalty figure is included in the payment/deductible error rate when a carrier fails to review all sample claims.

For FY 79, the total payment/deductible dollar error with penalty increased 0.1 per cent from FY 78. The mean carrier error rate increased from 2.1 to 2.2. A loss to the Medicare program of $5,864,000 was realized in FY 79, due to an increase in the national overpayment error rate. The current national overpayment error based on 56 carrier locations (only 52 reported as of December 31, 1979) is 1.19, indicating that $1.19 was estimated to be overpaid per $100 of submitted charges. For FY 78, this error rate was $1.14.

Contracting Initiatives - Under Section 222 of P.L. 92-603, HCFA was granted experimental authority to test incentive contracting for intermediary and carrier administrative functions. Under an incentive contract, intermediaries and carriers are reimbursed on other than a cost related basis, rather than on the basis of actual costs incurred. They are at risk and may suffer monetary damages for failure to meet performance objectives. As a result of assuming the risk of non-performance, the intermediary or carrier is under greater internal management direction to achieve improved efficiency and economy in operations than would probably be achieved in a risk-free management environment. HCFA has taken action in the experimental contracts to assure that a continuing high level of service to Medicare beneficiaries and providers is maintained. In each experimental contract performance requirements have been introduced which exceed those applied to the incumbent contractors reimbursed on a cost basis.

The use of incentive contracts on an experimental basis, authorized by Congress in 1972, is a departure from the basic statutory authority directing

HCFA to reimburse contractors for the necessary and proper cost of administration of their contract duties. The experimental contracts which utilize selected performance standards and existing quality control and performance review procedures provide for the assessment of liquidated damages if the contractor fails to meet the standards established. Evaluations are made of actual performance against the standards on a quarterly basis by regional staff.

The experimental contracts are being evaluated to determine the advantages and disadvantages of these forms of contracts. Although the evaluations are not complete, some preliminary observations have been made. The process of selection and subsequent negotiations of these experimental contracts has demonstrated the willingness of both the Blue Shield Plans and commercial insurance companies to operate in an incentive/risk environment and use specific standards to measure performance which may result in monetary damages being assessed for poor performance. By FY 78, four experimental contract forms had been awarded for the Maryland, Maine, Illinois, and upstate New York carrier service areas. The first was an annual prospectively negotiated fixed rate experiment with an incumbent carrier. The second, third, and fourth were competitively bid fixed-price contracts for Part B carrier geographic areas.

The Maryland Blue Shield contract was the first incentive-type reimbursement contract between HCFA and one of its Part B contractors. This type experimental contract was an annual prospectively negotiated fixed rate experiment. This prospective fixed rate contractual agreement with Maryland Blue Shield followed a general solicitation to all Part B Medicare carriers for participation in a fixed rate experiment. Nineteen carriers responded to the general solicitation. The experimental fixed rate contract with Maryland Blue Shield was for a 2-year period (calendar years 1977 and 1978). In the experiment, Maryland Blue Shield realized net earnings in the first year of $274,161, which included a reduction in payments for failure to satisfy one of the performance requirements in the agreement. The second operational year (calendar 1978) of the contract had a negotiated fixed rate 8.1 per cent below that which was negotiated in the first year of the contract. During 1978, the contractor sustained a net loss of $74,597, thus realizing a net gain over actual incurred costs of $199,564, or 2.64 per cent, for the 2 years.

In Maine, the Union Mutual Life Insurance Company decided not to renew its contract as the Medicare Part B carrier. Rather, the company decided to concentrate its efforts and resources on private business. Its decision not to renew the contract and the relatively small claims volume for Maine presented an ideal opportunity to test the competitive fixed rate concept in Medicare under the experimental provisions of Section 222 of P.L. 92-603. Through competitive selection, Blue Shield of Massachusetts (BSM) was chosen to replace Union Mutual. BSM has contracted with HCFA to process Part B medical insurance claims for a fixed-price from December 1977 through September 1980. The contract holds BSM to performance standards, including provisions for liquidated damages in the event of substandard performance. It further provides for contract termination in the event of substantially poor performance. The projected savings resulting from this experimental contract are $772,600. During FY 79, HCFA and BSM successfully negotiated a 1-year extension to the existing contract to process the Maine Part B workload for a price of $2,140,227, bringing the total cost of the contract for the period December 1, 1977 - September 30, 1981 to $7,425,227.

The HCFA experimental fixed-price contract in Illinois is intended to test the effect of merging carrier service areas and the cost benefit effects of price competition in a medium claims volume service area. The service areas involved are Cook County formerly serviced by the Health Care Service Corporation (HCSC) and the remainder of the State of Illinois formerly serviced by Continental Casualty (CNA). The operational period of the fixed-price contract is April 1979 to September 1983. The successful offerer for this contract was Electronic Data Systems Federal Corp. (EDSF), a non-medical care insurer experienced in medical claims processing. The projected savings to be realized by this experimental contract are $34,790,200.

In New York, HCFA selected through a competitive process, a Part B carrier for the upstate New York area. The area was previously serviced by Blue Shield of Western New York, Genesee Valley Medical Care, Inc., and Metropolitan Life Insurance Company. The experimental contract there is intended to test the cost benefit effect of merging three carrier service areas in the aggregate medium claims volume service area. The successful offerer for this contract was an incumbent carrier, Blue Shield of Western New York (BSWNY). The operational period of this contract is June 1979 to September 1982. The projected savings to be realized from this contract is $15,593,300.

During 1979, HCFA completed the implementation phase of both contracts. In Illinois, EDSF assumed the HCSC workload on April 1, 1979, and the CNA workload on July 1, 1979, as contractually required. Similarly, in upstate New York, BSWNY assumed the workload of the Genesee Valley Medical Care, Inc. and Metropolitan Life on August 1 and October 1, 1979, respectively. Operational status was achieved by EDSF on July 1, 1979 and by BSWNY on October 1, 1979 and their performance has been under continuous review. EDSF's performance under the experimental contract becomes subject to liquidated damage assessments with the October-December 1979 quarter and in the case of BSWNY with the January-March 1980 quarter.

The first fixed-price competitive bid contract under Part A was to have been awarded for the State of Missouri on July 2, 1979. The term of the contract was to have been January 1, 1980, through December 31, 1982. Court action was initiated against DHEW and on June 29, 1979, the U.S. District Court for the Western District of Missouri rendered a decision which enjoined DHEW from making an award in the procurement. Among other things, the parties initiating the suit contended that the planned experiment violated existing Medicare legislation, which permits participating providers of health care services to nominate their Part A fiscal intermediary. On August 27, 1979, DHEW filed an appeal with the U.S. Court of Appeals for the Eighth Circuit requesting a reversal of the lower court's decision. A decision is expected from the Court of Appeals by April 1980.

For an experiment to test the potential efficiencies of merging several contractor operations in a multi-State environment and the feasibility of a common claims process for the Medicare Parts A and B progress, an RFP in the Colorado, Utah, and Wyoming service area was released on August 2, 1979. A preproposal conference on the RFP was held on September 12, 1979. On September 14, 1979, the Blue Cross Association, along with Blue Cross/Blue Shield of Colorado, Blue Cross/Blue Shield of Wyoming and Blue Shield of Utah, filed a suit with the U.S. District Court for the Western District of Wyoming requesting that DHEW be enjoined from conducting this experiment. The issues in the litigation are similar to those in the Missouri litigation. On

November 1, 1979, the Court enjoined HEW from awarding a contract under this proposed experiment. On December 31, DHEW filed an appeal with the U.S. Court of Appeals for the 10th Circuit.

Experimental fixed-price competitive procurement is but one means by which HCFA is seeking to maximize program efficiency and effectiveness to beneficiaries while at the same time reducing adminstrative cost. A second approach is the reduction in the number of contractors by reassignment of contractor territories via administrative action. For example, in the State of Wisconsin there were two contractors, Wisconsin Physicians Service (WPS) and The Medical Society of Milwaukee County (Milwaukee Blue Shield). Wisconsin Physicians Service processed 70 per cent of the Part B workload and MBS processed 30 per cent. The Milwaukee Blue Shield Plan was notified in June 1979 that its contract would not be renewed, effective October 1, 1979. Its work would be handled by Wisconsin Physicians Service. The transitional activity was completed and the successful transfer of workload occurred on October 1, 1979.

Other FY 79 Ongoing Performance Improvement Initiatives:

1. Intermediary Systems Testing Project

The intermediary Systems Testing Project (ISTP) is designed to check the quality of the intermediaries' claims processing operations. ISTP consists of a test file of approximately 120 claims which are used to determine an intermediary's ability to make correct entitlement, eligibility, and utilization determinations. Testing is repeated if major computer changes are made or if an intermediary's claim process proves to be deficient. In 1979, 82 intermediaries were tested.

A survey of 50 of those intermediaries, indicated that of the 118 test claims submitted to each intermediary, an average rate of 21 errors per test was encountered. Major common errors encountered were:

1. Visual comparison of claims for appropriateness of treatment to diagnosis (e.g., tonsillectomy for appendicitis) was not adequately performed.

2. Claims showing a termination/date of death were not processed correctly.

3. Overlapping billing dates/linking benefit periods were not detected.

2. Carrier Systems Testing Project

The Carrier Systems Testing Project (CSTP) is designed to check the quality of the carriers' claims processing operations. CSTP is designed to test all facets of a carrier's claim processing system, beginning with the clerical input of approximately 150 test claims, to the final disposition of the explanation of benefit notices (EOMBs). Testing is repeated if major computer changes are made or if a carrier's claims process proves to be deficient. In 1979, 42 carriers were tested.

A survey of 10 carriers indicated that of the 151 test claims submitted to each carrier, the average rate of errors per test was 32. Major problems encountered were:

1. Excess queries.

2. Failure to follow "dummy" doctor profiles as set by CSTP.

3. Improper use of query codes.

4. Failure to state the correct deductible on the EOMB.

In the past, carriers that failed to achieve a CSTP score of 85 were required to be retested within 90 days. No such system existed for intermediaries. However, with the 1980 test cycle, carriers must achieve a CSTP score of 90, while intermediaries must attain an ISTP score of 70. Contractors failing to achieve their required score will be retested at the discretion of the regional office.

3. Reducing Paperwork

A growing number of providers of Health Care Services are keeping records by computer. The Health Care Financing Administration began an initiative to take advantage of this technology by encouraging providers to submit claims to carriers and intermediaries in machine readable format. This saves the contractors the cost of converting the data from hardcopy to computer tape and reduces claims processing time. Medicare contractors will be directed to establish a system to accomodate claims prepared on magnetic tape using a national standard input format, and to produce national standard output tapes for use of automated billers, complementary insurers, and Medicaid claims processors. Substantial cost savings will be achieved for both the Medicare and Medicaid programs. National standards are being developed for electronic information interchanges between Medicare carriers and physicians, suppliers, and their billing agents; Medicare intermediaries and providers; Medicare contractors and complementary insurers in the private sector; and, Medicare and Medicaid where there is joint entitlement. The standards should be completed before the end of FY 80.

4. Provider Uniform Billing

Activity proceeded during 1979 on both the American Hospital Association sponsored provider bill (UBF-1), developed by the New York State Office of Health Systems Management under a grant from the Health Care Financing Administration.

Tests of the UB-16 were begun in Ohio (April), Florida (July), and Connecticut (September). Tests will begin early in FY 80 in Nevada and Arizona. Each State is scheduled to continue testing for an 18-month period to determine the impact on cost and operations (hospital and intermediary).

C. REIMBURSEMENT CONTROLS/POLICY INITIATIVES

Medicare reimbursement to participating providers (i.e., hospitals, skilled nursing facilities, home health agencies and certain other organizations supplying health care services, such as renal dialysis facilities, rural health clinics, and outpatient physical therapy providers) must, under the law, be on the basis of the "reasonable costs" of furnishing covered services to program beneficiaries. The law also requires that reimbursement for covered services furnished by physicians and others who customarily render services on a charge basis is based on "reasonable charges" for such services.

It has been essential that the Medicare program, in the interest of both its beneficiaries and the general public, establish tests of "reasonableness" which do not impair the delivery of high quality health services or inhibit access by beneficiaries to the health care delivery system. At the same time, Medicare must assure that unwarranted costs and charges are not imposed upon the program. In FY 79, several initiatives were undertaken to contain program costs without reducing the quality and accessibility of health care services to program beneficiaries.

Reasonable Cost Reimbursement Initiatives

1. Reasonable cost limits - Previously, reimbursement of the reasonable costs of participating hospitals, skilled nursing facilities, home health agencies, and outpatient physical therapy facilities included all necessary and proper expenses incurred in the delivery of patient care. Medicare recognized, however, that reimbursement on the basis of incurred costs does not offer sufficient incentives to promote the degree of efficiency and economy necessary to stem the rapid escalation of health care costs. The enactment of Public Law 92-603, the Social Security Amendments of 1972, greatly enhanced the Health Care Financing Administration's capability to control cost escalation. Section 223 of P.L. 92-603 amended the definition of reasonable cost in Section 1861(v)(1) of the Social Security Act to exclude costs determined to be unnecessary in the efficient delivery of needed health services. The intent of the Congress, as expressed in the Committee Reports, was to prevent reimbursement of costs attributable to operating inefficiencies or excessive service. Congress reasoned that health care institutions, like other enterprises, should face the financial consequences of inefficiency. The Amendments authorized the establishment of prospective limits so that providers could act to keep their costs within the limits. Under previous practice, the disallowance of costs after they had been incurred created financial uncertainty which resulted in planning problems for providers. The establishment of prospective limits, however, reduced this uncertainty by defining limits prior to the onset of the cost reporting period to which they applied.

Regulations implementing Section 223 authorized the establishment of prospective cost limits based on the classification of providers according to appropriate factors such as similarity in size and economic characteristics. The regulations also established the conditions under which providers may be

entitled to a change in classification, an exemption from the limits, or an exception to them. The statute and regulations also provided for relief by allowing a provider, under certain circumstances, to charge excess costs to the beneficiary.

In granting the authority to establish prospective ceilings on reasonable costs, Congress was aware of the difficulties that could arise because of deficiencies in cost data, or because of limitations in measuring health care output and defining efficient delivery of care. Congress recognized that the initial limits would , of necessity, be imprecise and affect a relatively small number of providers. The expectation was that cost limits would be established to the extent currently feasible with continuing refinement as appropriate methodology developed.

Although Section 223 of P.L. 92-603 authorized cost limits for all types of providers, it was decided, in view of the amount of reimbursement involved, to first apply limits to hospital costs. Subsequently, limits were developed for home health agency costs and skilled nursing facility costs.

Pending the development of a hospital classification system sophisticated enough to consider such variables as case-mix and the nature and scope of services, limits were placed only on hospital costs for general routine services. Basically, routine service costs are the costs of room, board, and nursing services. They exclude any costs associated with ancillary services and special care units, such as intensive care or coronary care. Routine costs should be comparable for hospitals of similar size and in similar economic environments.

The hospital routine cost limits are derived from the reported per diem inpatient routine costs of comparable hospitals. Comparability is achieved by classifying hospitals according to bed size and location. The classification system is designed to produce reasonably homogeneous groups so that costs of similar hospitals are compared. The hospital classification system uses predetermined criteria to assign each hospital to the appropriate group. The criteria are uniformly applied so that the basis of classification is the same for each hospital. Under these circumstances, extremely high costs can be presumed, in the absence of evidence to the contrary, to be greater than the cost necessary to deliver health services efficiently. The cost limits, therefore, restrict the recognition of reasonable cost to a standard cost representative of that experienced by similar hospitals.

After classification is completed, based primarily on hospital location and bed size, the cost limit for each group of hospitals is computed based on the per diem inpatient routine operating costs of the providers within each group. The inpatient routine operating cost used in the computation excludes capital related costs and the costs of approved medical education programs. These costs were excluded in order to achieve homogeneous groupings of hospitals. It was impractical to account for variation in capital and medical education costs within the classification system.

The inpatient routine operating cost data are obtained from the Medicare fiscal intermediaries. The data for the hospitals in each group are arrayed in descending order and the limit is set at the 80th percentile of each group. This amount is adjusted by an estimate of the expected annual increase in

routine costs which will occur following data collection, based on a market basket of goods and services typically consumed by hospitals.

The adjusted amounts are the cost limits published in the Federal Register. The method of applying the hospital cost limits recognizes differences in routine operating costs related to two factors not considered in the classification system. The portion of the cost limit related to wages is adjusted by an area wage index to account for differences in area wage levels. The area wage index is derived from data on hospital wages obtained from the Bureau of Labor Statistics. A utilization index based on Medicare covered days per 1,000 beneficiaries is used to recognize higher routine operating costs in areas where lower utilization is achieved through greater intensity of service. The hospital cost limits comply with Congressional intent to recognize legitimate variation in costs among hospitals, and limit reimbursement only for providers whose costs are significantly greater than those of the comparison group. The schedule of limits is revised periodically to reflect changing hospital costs and modifications of the classification system.

Section 223 limits were established in FY 79 on the cost per visit of home health agencies. Cost variations among agencies rendering similar services have been shown to be quite substantial. The Section 223 principle (that Medicare should not pay for costs which are unnecessary in the efficient delivery of health services) is clearly applicable to costs incurred by home health agencies. This principle is particularly relevant because almost all services provided by some home health agencies are furnished to Medicare beneficiaries. Therefore, the full allowable costs of these agencies are borne by the Medicare program.

The home health agency cost limits are derived from the per visit costs of home health agencies for each of six Medicare covered services; skilled nursing care, physical therapy, speech pathology, occupational therapy, medical social services and services of home health aides. A substantial differential was observed between agencies operating in metropolitan and non-metropolitan locations. Therefore, home health agencies were classified into two groups on the basis of location.

After classification, a cost limit was computed for each type of service. The limit was based on the per visit cost for each service of home health agencies in each group. The per visit cost data are obtained from the Medicare fiscal intermediaries. The data for the home health agencies in each group are arrayed by type of service in descending order. The limit is set at the 80th percentile for each type of service within each group. This amount is adjusted by an estimate of the expected annual increase in per visit costs which will occur following the data collection. The adjustment is based on actuarial estimates of increases in interim payments for home health services and a formula for voluntary price restraint in the health care sector established by the Council on Wage and Price Stability.

The adjusted per visit amounts are the home health agency cost limits published in the Federal Register. Although limits are developed for each type of service, the various cost finding methods currently used by home health agencies make it impractical to apply the limits directly to the per visit costs of individual services. Therefore, home health agency cost limits are applied on an aggregate basis by multiplying the limit for each service by the number of visits in that service. The sum of the resulting amounts is compared to the home health agencies aggregate allowable Medicare cost.

The schedule of limits is revised periodically to reflect changing home health agency costs and modifications of the classification system. Work began in FY 79 to modify cost finding requirements so that the home health limits could be applied directly to each type of service and to determine whether the method used to set the home health cost limits could be refined to reflect factors such as differences in area wage levels. An improved system for establishing home health agency cost limits is expected to be published in FY 80.

Work was completed in FY 79 on the development of Section 223 limits on the inpatient routine service costs of skilled nursing facilities. The initial schedule of limits was published in final in the Federal Register on August 31, 1979 to become effective October 1, 1979. However, on February 22, 1980, an amendment to this initial schedule of limits was published in the Federal Register which suspended the previous requirement that the limits be applied to Medicaid skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). This decision, effective October 1, 1979, is primarily the result of technical problems encountered by State Medicaid Agencies in applying the schedule of limits. The basis for these problems is the varying methods of payment and determinations of allowable cost available to the State Agencies. Additional comments have been requested to determine the most appropriate method to establish limits on Medicaid payments for SNF and ICF services.

The skilled nursing facility routine cost limits are similar in design to hospital routine cost limits. Skilled nursing facility routine cost limits are derived from the reported per diem inpatient routine costs of comparable skilled nursing facilities. Skilled nursing facilities are classified according to location and status as a free-standing or hospital-based skilled nursing facility (SNF). Hospital-based SNFs are an integral part of an affiliated hospital and, as a class, incur higher costs. The higher costs are attributable, at least in part, to cost allocation requirements for distributing hospital overhead costs to the SNF departments. The classification system is designed to produce reasonably homogeneous groups so that costs of similar SNFs are compared. Under these circumstances, extremely high costs can be presumed, in the absence of evidence to the contrary, to be greater than the costs necessary to efficiently deliver skilled nursing facility services.

After classification is completed, the cost limit for each group is computed based on the inpatient routine per diem costs of SNFs within each group. The inpatient routine cost data are obtained from the Medicare fiscal intermediaries. The data for the SNFs in each group are arrayed in descending order and the limit is set at 115 per cent of the mean cost, excluding capital-related costs of the SNFs in each group. This amount is adjusted by an estimate of the expected annual increase in routine costs which will occur following data collection based on a market basket of goods and services typically consumed by skilled nursing facilities.

The adjusted amounts are the cost limits published in the Federal Register. As in the hospital cost limits, the method of applying SNF cost limits recognizes differences in routine per diem costs resulting from area wage differentials. The portion of the cost limit related to wages is adjusted by an area wage index derived from data on hospital wages obtained from the Bureau of Labor Statistics. Hospital wage data are used because of the lack of wage data specific to nursing facilities. SNF cost limits comply with

Congressional intent to limit reimbursement only for those providers whose costs are significantly greater than those of comparable facilities. The schedule of limits will be revised periodically to reflect changing SNF costs and modifications of the classification system.

2. Salary-related reimbursement of certain therapy services - During FY 79, HCFA continued work to implement salary equivalency guidelines for physical therapy and respiratory therapy services furnished under arrangements between providers and independent contractors. These guidelines were developed under authority contained in Section 1861(v)(5) of the Social Security Act. Section 1861(v)(5) requires HCFA to develop criteria for determining the reasonable cost of services furnished by therapists or other health care specialists (except physicians) under arrangements with a provider.

   The purpose of this section of the law is to control expenditures and prevent abuse. Abuse generally occurs through the provision of many separately counted services rendered by therapists who contract with providers. The providers have little or no financial incentive to control therapy cost because these costs will be passed on in large part to the Medicare program and other payers. Also, these services are often furnished by persons who themselves are salaried employees of a contractor. The contractor then charges the provider on the basis of a fee-for-service or a percentage of billed charges.

   Under the law, Medicare reimbursement for these services may not exceed an amount equal to the prevailing salary and fringe benefits that would have been payable by a provider had the services been performed by a provider employee, plus an allowance for other expenses related to furnishing these services. The definition of prevailing salary is based on the 75th percentile of the range of salaries paid to full-time therapists, using data compiled by the Bureau of Labor Statistics. The Medicare guidelines establishing these limits also contain a fringe benefit and expense factor. Additional allowances are made for travel, overtime, equipment and supplies, and aides and assistants furnished by the contractor.

   During FY 79, HCFA issued updated guidelines for physical therapy services and initial guidelines for respiratory therapy services.

3. PSRO Review Costs - Under the law, Professional Standards Review Organization's (PSRO) review costs are financed through the Medicare trust funds. The legislative and executive branches of the Government have expressed concern over the costs of PSRO review. This concern led to the establishment of a budgetary limit on the amount of money which could be expended from the trust funds for PSRO hospital review during FY 79.

   To comply with this limit, HCFA directed PSROs nationwide to reduce costs. Since the Medicare fiscal intermediaries are responsible for final settlement of all review costs in delegated hospitals (i.e., where the hospital itself performs review under delegation from the PSRO), they must play an integral part in any effort to reduce

costs. Therefore, instructions were issued to the intermediaries concerning specific steps which they must follow when settling delegated review costs. These instructions included review procedures which the intermediary must employ in analyzing these costs. They also directed the intermediaries to consult with the PSROs in every case where a delegated hospital's review costs exceeded the budgeted amount approved by the PSRO at the beginning of the hospital's cost year.

4. Primary Care Intern and Resident Programs - In the Findings and Declaration of Policy by Congress in the Health Professions Act, the Congress stated that physician specialization has resulted in inadequate numbers of physicians to deliver primary care. This is of concern because the Congress believes that primary care physicians are critical to meeting the nation's health manpower requirements.

   In keeping with the intent of Congress, HCFA published a Notice of Proposed Rulemaking which will change current regulations and encourage the development of intern and resident programs in primary care. Current regulations specify that, in determining the costs reimbursed under Medicare, the provider may include the net cost of approved intern and resident programs. Net cost is determined by deducting all grants, tuition, and specific donations from the provider's cost for the programs. The proposed change would not require the deduction of grants and specific donations in determining the net cost if they were received by the provider specifically to support intern and resident programs in primary care.

5. Home Health Agency Reimbursement Initiatives - In recent years, a spotlight has been placed on the increasing costs of providing home health services through home health agencies. As a result, a series of detailed program instructions were issued in prior years to enable intermediaries to more uniformly analyze the necessity for and reasonableness of home health agency operating costs.

   In response to continuing Congressional concern in this area, HCFA issued further instructions in 1979. Those instructions stressed the regulation which mandates provider documentation of claimed costs and the importance of providers consulting with their intermediaries regarding the allowability and reasonableness of costs they plan to incur, especially with regard to fring benefits. Additional instructions emphasized the nonallowability of costs associated with HHA attempts to solicit patient referrals from hospitals and provided additional detail with regard to the costs incurred for specific types of advertising. These efforts have been directed toward enhancing the effectiveness and value of home health services through more oversight of agency operations.

   HCFA is continually reevaluating its policies with regard to home health services. It is currently involved in a multi-bureau effort to review all aspects of home health care as to the effect of and necessity for further program guidance in this area.

6. Direct Apportionment of Malpractice Costs - During 1979, HCFA published final regulations governing the direct apportionment of malpractice costs to the Medicare program. The purpose of the regulations is to reimburse Medicare providers on a basis more closely related to actual malpractice experience.

Under the prior regulations and related instructions, malpractice costs were apportioned to the Medicare program on the basis of Medicare's overall utilization of provider services. This method resulted in Medicare paying a disproportionate amount of malpractice costs. A national study conducted by an HEW consultant indicated that malpractice awards for Medicare patients are significantly lower in amount than awards for non-Medicare patients. The lower awards for Medicare patients resulted because the income potential and life expectancy of these patients are less than the non-Medicare population. Thus, the use of overall Medicare utilization to allocate malpractice costs resulted in Medicare paying a disproportionate amount of malpractice costs.

The new regulations avoid these disproportionate payments by directly apportioning to Medicare the provider's malpractice costs specifically identified to Medicare. They impact Medicaid reimbursement in States which have adopted Medicare principles for determining reasonable cost reimbursement. These regulations should result in an annual savings of $270 million to the Medicare program. An additional $40 million in savings should be realized by the Medicaid program.

7. Elimination of the Combination Method of Apportionment and Modified Cost Finding for Providers - In early 1979, HCFA published final regulations which eliminated the Combination Method of apportionment and modified cost finding used to determine Medicare reimbursement for health care services rendered to Medicare beneficiaries by health care facilities participating under the Medicare program. The purpose of the regulations is to achieve greater uniformity in determining cost reimbursement under the Medicare program.

The purpose of a method of apportionment is to determine what portion of a health care provider's cost is properly attributable to furnishing services to Medicare beneficiaries. The purpose of a method of cost finding is to determine the full cost of routine revenue-producing departments, ancillary revenue-producing departments, and activities for which reimbursement is not allowed under Medicare. The prior regulations provided for two methods of apportionment and cost finding. The requirement that certain providers use the simpler Combination Method of apportionment and modified cost finding, and that other providers use the more precise Departmental Method of apportionment and step-down method of cost finding, was established in accordance with the report of the Senate Finance Committee (S. Rep. No. 91-1431, 91st Cong., 2d sess. 178 (1970)). However, after requiring the use of these two methods, HCFA received a significant amount of correspondence from providers and from Congressmen on behalf of providers required to use the simpler method. The providers expressed the desire and ability to

use the more precise Departmental Method of apportionment and step-down cost finding. A subsequent survey revealed that all but a few of the providers using the Combination Method could develop the necessary statistics to enable them to use the Departmental Method. A majority of the providers surveyed stated a preference to use the Departmental Method. In addition, although the Combination Method of apportionment originally offered some simplicity in the manner in which the Medicare program determines its share of the smaller and less complex providers' allowable costs, legislative amendments affecting the Medicare program since 1972 no longer permit this simplicity. Consequently, HCFA decided to eliminate the simpler Combination Method of apportionment and modified cost finding.

8. Reimbursement of the Costs of Blood - During 1979, HCFA began taking steps to more aggressively monitor the application of reimbursement policies when making payment for blood and blood products. The purpose is two-fold: (1) to assure that hospitals receive appropriate reimbursement for the services provided, and (2) to assure that the Medicare program and its beneficiaries do not bear an inequitable portion of the costs.

In late summer 1979, HCFA distributed for comment special instructions which discuss in detail the considerations applicable to reimbursement for blood and blood products. By focusing discussion on the manner in which general reimbursement principles are to be applied in this specific area, HCFA expects to achieve more uniform and effective administration of the blood reimbursement provisions.

Specifically, the special instructions address such topics as:

(1) The need to assure that blood replacement credits are granted to Medicare beneficiaries under the same conditions as non-Medicare patients.

(2) The proper treatment of nonreplacement fees when apportioning hospital costs. If a hospital obtains replacement blood for a processing fee only, it will not be allowed to also include a non-replacement fee when recording its charges.

(3) Evaluation of costs incurred by hospitals which obtain blood from independent blood banks. Intermediaries must assure that hospitals exercise prudent business management when entering into contracts with blood banks.

(4) The responsibility of intermediaries to reopen and adjust past cost reports when significant aberrant charging practices are identified.

HCFA expects to publish the special instructions in early 1980. Shortly thereafter, these special instructions should be reinforced by proposed expanded regulations which more explicitly specify provider and intermediary responsibilities.

1. Laboratory Services and Durable Medical Equipment Subject to Lowest Charge Level Provision - The Medicare regulation establishing procedures and standards to implement portions of Section 1842(b)(3), including the methodology for calculating the lowest charge level, is found in 42 CFR 405.511. The Medicaid regulation adopting the Medicare lowest charge criteria is found in 42 CFR 447.351. The regulation limits reasonable charges to the lowest charge levels at which designated services and items, that do not vary significantly in quality from one supplier to another, are widely and consistently available in the locality. The regulation was implemented during FY 79. An initial list of 2 items of durable medical equipment and 12 most commonly performed laboratory services, to which the lowest charge level limitation applies, was published in the Federal Register on July 26, 1978, (43 FR 32335), along with the final regulation.

   On January 24, 1979, HCFA published in the Federal Register a proposed notice of laboratory tests commonly paid for by Medicaid, but not Medicare, that would be subject to the lowest charge level limits. Similarly, a proposed notice for the Medicare and Medicaid programs was published in the Federal Register on March 26, 1979. The notice identified 15 additional laboratory services and 5 additional items of durable medical equipment as falling within the scope of the regulation.

D. IMPROVING UTILIZATION SAFEGUARDS

One of the most critical areas of Medicare program activity is to establish safeguards against improper and excessive utilization of health care services. A large part of the rapidly increasing costs of Medicare is attributable to the furnishing of medical services for which Medicare claims submittals are made, which are not medically necessary by reference to generally accepted medical practice norms, or which are medically inappropriate, particularly in terms of location of care. Most overutilization situations do not represent any criminal intent to defraud the Medicare program. Usually they represent "decisions of opportunity"; i.e., when a service opportunity is presented which is reimbursable by an external party and there is a lack of rigorous definition about the nature of the service or the reimbursement rules for that service, there is an incentive to render the service with a high degree of expectation that it will be reimbursed. The delivery of medical care is particularly subject to this incentive because the necessity and appropriateness of such services are often judgmental matters. Additionally, some medical practices which tend to induce overutilization have become traditionalized in the American health care delivery system.

Under the hospital insurance program, one of the most obvious examples of this is unnecessary occupancy of expensive inpatient facilities, when health services at that level of care are not required. An admission to a hospital for services which could be given in a skilled nursing or intermediate care facility or on an outpatient basis, with equal medical effectiveness, is a particularly striking example of such a situation. A Friday admission to a hospital whose laboratory is closed on weekends, when the initial purpose of the admission is to secure diagnostic services, is another obvious situation in which costs are inappropriately generated. Extended stays in a facility beyond the patient's medical need for that facility's level of care creates a far higher care cost than should be incurred by either the patient or his insurer.

In the medical insurance program, excessive or unnecessary utilization often occurs because the common charge structure for medical services, whether in an outpatient hospital setting or in respect to services furnished by private physicians, is generally that a fee is charged for each visit. Under such a system, program reimbursement can be substantially increased solely as a result of an increased number of visits. That increase in number of visits may or may not represent a proportionate increase in either the quantity or quality of medical services rendered. Thus, patients may initiate physician or outpatient visits which their medical needs do not require, or may request additional visits after their current medical needs have been met. Additionally, physicians and outpatient clinics may invite or allow more patient visits than are required for the patient's medical management or which customary practice would ordinarily dictate.

The program has approached its responsibilities in the area of utilization safeguards in a number of ways. First, of course, the structure of the program itself provides some fundamental controls and safeguards. There are benefit limitations on the number of days of care in hospitals and extended care facilities and for home health visits. These limits are intended to assure coverage for the vast majority of medical situations that require these levels of service and yet provide upper limits beyond which program payment would not be made. The program prescribes deductible and coinsurance amounts

which may serve as a safeguard against the initiation of unnecessary services because they require patients to share the cost of services and, thus, provide some motivation to them not to seek services unnecessarily or prolong services beyond their medical needs. Particularly significant are the program requirements that, for services to be reimbursable, they must be furnished on a physician's order or under the direction of a physician. Additionally, for inpatient services to be reimbursable, a physician or a Professional Standards Review Organization (PSRO) must certify that they are medically necessary. Also, section 1862(a)(1) of the Social Security Act provides that under both the hospital and medical insurance programs, payment may not be made for services which are not reasonable and necessary for the diagnosis and treatment of illness and injury.

Secondly, HCFA has continued to refine the prepayment and postpayment screens which intermediaries and carriers utilize to identify situations of potential overutilization or variations from medical necessity norms.

A particularly important screen, utilized by many carriers, permits the prompt identification of individual physicians whose total bills for Medicare patients in given periods significantly exceed what would normally be expected in ordinary practice. Investigation of physicians identified by means of such a screen can disclose instances of overutilization or cases in which the physician's practices are sufficiently questionable to warrant reporting to the State or local medical society or even cases of deliberate fraud in which prosecution would be appropriate. The increasing awareness that cases involving possibly excessive rates of payment are being investigated constitutes a significant deterrent to overutilization.

Other types of screens which are being increasingly used by carriers provide for the identification of (1) physician-patient contacts which appear abnormally frequent for a particular diagnostic category or therapeutic procedure, (2) potential markup situations where physicians include an added charge for services actually provided by an independent laboratory, or (3) situations in which a physician begins charging separately for component services which had previously been rendered as a combination of package service with a single charge. Carriers are increasingly incorporating such screens into their electronic data processing systems.

It is important to recognize that in many instances variations from usual patterns are justified by the facts of an individual case. The important thing, however, is that the Medicare claims review process must be able to identify significant variations so that further review can be undertaken in instances where the possibility of excessive or improper utilization should be investigated.

Thirdly, HCFA is continuing its efforts to assure that Medicare payment is only made for items and services which are medically necessary and of acceptable professional quality. This activity takes a variety of forms. First, HCFA continues to identify individual items, services, and procedures which are of questionable value. When HCFA obtains medical evidence that an item, service, or procedure is not safe and effective or that it is experimental, it discontinues payment for it. HCFA conducts these activities with the support of the Public Health Service and in collaboration with national medical and medical specialty societies.

Another dimension of the medical necessity issue relates to determinations as to whether items or services provided to a beneficiary in a specific case are medically necessary. In recent years, criteria have been developed to assist Medicare intermediaries make these determinations. This is a very sensitive area, of course, since such determinations may directly challenge the medical judgment of the physician who ordered or rendered the services. Because this is such a sensitive area, review criteria are always developed by physicians, and denials are only made on the basis of a physician's professional judgment. The PSRO program, established in 1972, provides for organizations composed exclusively of physicians to develop and apply medical necessity criteria to services rendered in hospitals and nursing homes.

The inducements to the provision of services beyond medical need are considerable. These inducements range from pressure put upon physicians by patients who are familiar with popularized diagnostic and therapeutic procedures and exotic new technologies, to the increasing concern by physicians over potential malpractice suits for failure to provide the entire gamut of diagnostic and therapeutic procedures to every patient. The latter leads to what has been called "defensive medicine." Other inducements are the use of expensive new equipment beyond medical justification in order to amortize the high cost of such equipment and, for some, the inducement of simple avarice, under the rationalization that the additional service, even though unnecessary, does not harm the patient medically nor financially, since he or she "has insurance."

In dealing with these problems, HCFA works closely with professional organizations to assure that services are provided and reviewed in accordance with the best professional judgment. Of particular importance in the increasing attention HCFA is giving to these issues is the PSRO program. PSROs not only perform review of services, they provide peer incentives to improved medical practice and appropriate utilization. Data collected as a result of PSRO review also provides in information which helps intermediaries and carriers improve their claims screening activities. PSROs are described more fully in the following chapter of this report.

E. QUALITY AND APPROPRIATENESS OF CARE

A major goal of the Medicare program is to assure that its beneficiaries receive appropriate, quality health care services.

This is assured by requiring that those facilities caring for Medicare beneficiaries are structurally safe, clean, properly staffed, and provide needed services and that the actual care delivered to beneficiaries is of high quality. In addition to assuring the quality of services received, HCFA must make sure that services are necessary and performed at the most economical level consistent with good care. These efforts ensure a high quality of care for beneficiaries while simultaneously constraining health care costs.

This section will describe HCFA's interrelated quality assurance programs that fulfill the above functions, and the major FY 79 initiatives that took place in each program. These programs are: Standards and Certification, the Professional Standards Review Organizations (PSROs) program, End-Stage Renal Disease Medical Review Boards (ESRD/MRBs), and the Second Surgical Opinion program.

Standards and Certification

In accordance with the Social Security Act, any facility providing health care services to Medicare beneficiaries must meet certain health and safety standards before it is eligible to receive reimbursement from Medicare. In order to ensure that these standards are met, HCFA has provided for an annual survey of each facility. These surveys are conducted by each of the States under contract with the Department. In the case of hospitals, however, the law allows the privately-run Joint Commission on Accreditation of Hospitals' (JCAH) and American Osteopathic Association's (AOA) standards and surveys to be considered as having met the Federal government's requirements. Therefore States will only survey those hospitals not accredited by JCAH or AOA and will, on a sample basis, conduct surveys on JCAH and AOA hospitals in order to validate that the surveys conducted by these associations continue to meet Medicare requirements. If, as the result of a State survey, a facility fails to meet the Federal standards, it is not certified and therefore cannot receive Medicare money.

Generally, the Federal Standards and Certification program is responsible for establishing and updating Federal health care standards, developing State survey procedures, and monitoring surveys and standards enforcement. During fiscal year 1979, program emphasis was placed on (1) upgrading standards affecting the quality of services, (2) developing more efficient and effective survey procedures, (3) improving program management, and (4) reducing unnecessary expenses imposed by certain standards. Discussion of major FY 79 activities follow.

1. Skilled Nursing Facility/Intermediate Care Facility (SNF/ICF) Conditions of Participation

Conditions of participation establish the requirements for life safety, medical care, and physical and social environment that nursing homes must satisfy to participate in the Medicare program. The present regulations for SNFs and ICFs have been in effect since 1974. Since that time,

numerous factors have led to the need for revising regulations. These include the recognition of the need to orient standards to quality of care rather than procedural requirements; changes in methods of delivering health care to nursing home patients; recognition of the need to protect the rights of patients; the need to rely less on consultant services and strengthen inhouse capacity; the consolidation of the separate SNF and ICF regulations to make certification more efficient for facilities with both SNF and ICF beds; and others.

During FY 79, revised regulations were drafted to satisfy these concerns, which would require publication as a Notice of Proposed Rulemaking (NPRM).

2. Hospital Conditions of Participation

In FY 79, the NPRM for new hospital conditions of participation neared completion. The general thrust of these proposed hospital standards is to give hospitals increased flexibility in using their resources, while maintaining an acceptable level of health care and safety. This flexibility is necessary because the present, rather detailed, and complex standards are considered excessively burdensome and ineffective for some hospitals, especially smaller ones.

Because these standards can be met in different ways, specific performance measurement criteria (based on the size of the hospital, and the scope of complexity of services) development was initiated in FY 79. These criteria will be published at the same time the new final hospital conditions of participation are published and will be used in determining hospital compliance with the standards.

3. Survey and Certification Procedures (Subpart S)

Survey and certification procedures for Medicare and Medicaid were developed at the time these programs became law. Since that time, many elements have been found to be either missing from the procedures, not necessary, or inefficient. In order to meet these concerns, revision of these procedures is planned.

During FY 79, the major issues to be addressed for revision were identified and public hearings to discuss them were organized. These issues include (1) consumer involvement in the survey process; (2) the elimination of non-productive requirements; (3) consolidation of Medicare and Medicaid certification rules; (4) elimination of unnecessary differences between Medicare and Medicaid requirements; and (5) integration of quality assurance activities in State agencies. Based on the comments expressed at the hearings, an NPRM should be developed in early FY 81.

4. Fire Safety Evaluation System (FSES)

In FY 79, the Department published a Proposed Notice on the adoption of the FSES for hospitals, with a request for comment on both this proposal and on whether to apply the system to skilled nursing facilities (SNFs) and intermediate facilities (ICFs).

The FSES was developed, at DHEW's request, by the Department of Commerce's National Bureau of Standards (NBS). The purpose was to determine how various combinations of widely accepted fire safety features could provide a level of safety equivalent to that obtained by strict compliance with the Life Safety Code (LSC) of the National Fire Protection Association. The FSES is a new alternate method of evaluating a facility for compliance with the LSC. It offers two important advantages: (1) it allows the Department to eliminate a repetitive waiver system under the LSC and (2) it provides facilities flexibility in meeting LSC requirements.

In FY 80, HCFA expects to publish the Final Notice on the adoption of the NBS FSES for hospitals.

5. End-Stage Renal Disease Minimum Utilization Rates (ESRD/MURS)

The law requires minimum utilization rates for ESRD transplant and dialysis facilities. Conditions of coverage on standards for transplant and dialysis facilities include a numeric rate that the facility must meet in order to be certified. The conditions allow a facility a specified lower MUR for no more than two consecutive years in order to let a needed facility build up its rate, and then require the facility to meet MUR. MUR was considered necessary because it was felt that high quality care could only be provided in facilities that performed a minimum number of procedures annually.

Many facilities are currently being faced with Medicare payment termination because they are not meeting required MUR after two consecutive years. MUR has been challenged in the courts because no definitive evidence exists correlating the specified MUR with quality of care. Because of this lack of evidence, and the hardship created for patients who would need to find new facilities, a one year moratorium was placed on the MUR requirement in July 1979.

HCFA plans to study MUR in FY 80 to determine whether the current MUR is appropriate, needs modification, or legislative changes should be sought to eliminate MUR.

6. State Agency Evaluation Procedures

HCFA regional offices are mandated to evaluate State agency performance of survey and certification activities. However, in the past, limited guidance was given to the regional offices in terms of what activities needed to be evaluated and what uniform data had to be collected on which to base the evaluations. The result was evaulations that varied from region to region with no basis on which to compare performances.

In response to this situation, a draft directive was developed in FY 79 that basically mandates a minimum data set for State agency evaluations. Regions will be able to expand on this data set for their own evaluation purposes, but must collect the minimum to allow for national comparisons. This directive is expected to be finalized by mid-FY 80.

7. JCAH Validation Process

Only a brief summary of the validation process is included in this Medicare Annual Report. A detailed operational report on the validation process and an analysis of survey results will be submitted to Congress by August 15, 1980. The timeframe for receiving accreditation information from the Joint Commission on Accreditation of Hospitals (JCAH) and validation information from State Survey Agencies on fiscal year surveys prohibits integration of the two reports.

In accordance with the Social Security Act, hospitals accredited by the Joint Commission on Accreditation of Hospitals are deemed to meet most of the requirements for Medicare participation. The Secretary is required to perform surveys to verify that the acceptance of JCAH accreditation is an effective means of assuring the absence of serious deficiencies in participating accredited hospitals. Annually, the Department must inform Congress on the administration of the validation process.

Hospitals are chosen for these surveys as a result of either random selection within a statistically determined sample of accredited hospitals, or due to substantial allegations of the existence of conditions adverse to the health and safety of patients. In order to differentiate between the two types of surveys, those done for the former reason are known as validation surveys, and those done for the latter reason are called complaint investigations. The Department contracts with the State Agencies to perform the surveys. During FY 79, eighty-four validation surveys were performed and 124 complaint investigations were conducted.

At the end of calendar year 1979, a major investigation of the validation process was initiated. A number of significant problems were discovered, including:

- untimely withdrawal of JCAH accreditation as proof that a hospital meets the conditions of participation.

- unnecessary State surveillance for prolonged periods of time;

- excessive surveys; e.g., duplication by JCAH and State Agencies;

- unwarranted costs for the hospitals and the Federal government; and

- loss of resources available for other State monitoring activities, such as additional validation surveys.

Additional problems with the validation process were already under analysis. The intent was to improve the standards for surveys and the procedures used.

A plan of revision to the validation process has been proposed, although it is still nascent. Discussions surrounding the plan are underway with JCAH, and inherent administrative difficulties are being worked out. The changes should result in a more meaningful survey process at a cost savings. A full discussion on the nature and effect of the revisions will be part of the August validation report.

Professional Standards Review Organizations

The PSROs are responsible for assuring the quality of actual patient care practices in facilities that have been certified as meeting Federal health and safety standards.

In 1972, Congress enacted legislation calling for the establishment of PSROs to ensure that the health care services provided to Medicare and Medicaid beneficiaries are (1) of a quality that meets professionally recognized standards of care, (2) medically necessary, and (3) appropriately provided in the most economical setting. PSROs took the place of hospital and skilled nursing facility Utilization Review Committees which were found to be ineffective primarily because of their subjective nature. PSRO review, on the other hand, is considered to be an external "community-based" system. PSROs are comprised of practicing physicians in a locality who engage in various activities associated with the review of care. PSROs are required to review health care services delivered in hospitals and long-term care facilities. Eventually, they may expand their review system to cover ambulatory care.

There are 195 designated PSRO areas nationwide. At the end of FY 79, PSRO review had been implemented or initiated in 187 of these areas. Planning contracts exist in an additional three areas. Five PSRO areas are currently unfunded.

Fiscal Year 1979 could be characterized as a year of transition for the PSRO program. In FY 78, the emphasis of the program was changed from implementation activity to activity that is designed to improve individual PSRO performance. HCFA has undertaken agressive management initiatives to improve PSRO effectiveness, reduce the cost of PSRO hospital review, improve the financial management of PSROs, and assess the performance of PSROs. The activities, begun during FY 78, continued through FY 79 and will continue through FY 80. The most significant FY 79 activities are detailed below.

1. Objective Setting

   In an effort to further increase local PSRO impact, and promote PSRO effectiveness nationwide, the program has mandated that all PSROs have acceptable impact objectives. Impact objectives may be defined as those directed toward issues of utilization or quality of medical care. Aggressive objective-setting processes will increase effectiveness by assuring that review activities are directed specifically to outcomes. Particularly at a time when budget constraints severely limit a PSRO's ability to impact on a broad range of problems, the objective-setting process allows an organization to state, at the beginning of the year, what it intends to achieve and, at the end of that year, what it accomplished and why.

The capability of PSROs to set impact objectives derives from their review experience, and the availability of national, regional and local data. Since the process of setting impact objectives was new and unfamilar for many PSROs, the development of models and examples was an early priority. During the summer of 1978, HCFA worked with approximately twenty PSROs to formulate a range of objectives pertinent to the PSROs involved, but also potentially applicable to other PSRO sites. These models and examples have been used as part of the curriculum in a series of workshops for PSROs and HCFA staff on PSRO objective-setting.

During FY 79, HCFA developed and began implementation of a system, for both central and regional offices, to approve, monitor and document objectives and related impact. The PSRO funding renewal process now requires objectives as a basis for grant award. An inability or unwillingness to establish appropriate objectives is a consideration for nonrenewal or termination of funding.

The strength of the PSRO program is its reliance on peer review and local community initiatives. However, to further strengthen the objective-setting process HCFA is developing broad national goals for the program which will serve two major functions. First, these goals will identify those areas of national concern which PSROs should address if it is also a significant local problem. Secondly, HCFA will be better able to report program progress.

2. Cost Reduction

A major impetus for the objective-setting process has been cost reduction. With better management of the review process, PSROs can continue to be effective at lower costs. As PSROs were funded throughout 1979, their review budgets were reduced by an average of 30 per cent. To enable PSROs to effectively make this transition, HCFA provided specific assistance in financial management and revised the budget negotiation process to allow PSROs greater flexibility in their resource management. PSRO costs have been analyzed to identify areas of efficiency within individual PSROs which can be utilized by other PSROs. "Models" demonstrating how review costs might be structured to achieve the necessary reductions have been developed and provided to PSROs.

During 1979, all PSRO budgets were negotiated at lower rates so that by the end of the fiscal year the negotiated cost of review averaged approximately $8.70 per discharge, as opposed to an average of about $13 in 1977.

3. Focused Review

Related to the cost reduction initiative was the increased attention devoted to what is known as "focused review". Prior to this new emphasis, most PSROs had been reviewing almost all cases in equal detail. This approach was very expensive because it required considerable personnel. Through focusing, PSROs place greater emphasis on the particular diagnoses, procedures, hospitals, or physicians where problems have been identified. Those cases which do not represent problem areas are still abstracted and reviewed on a

statistical basis. Many PSROs are now intensively reviewing about 50 per cent of the discharges in order to remain within the limitation for review expenditures.

4. Termination and Consolidations

During the past year HCFA has taken a variety of management steps to deal with poorly performing and cost ineffective PSROs. HCFA has discontinued support of three PSRO contracts and has given notice that two other PSRO contracts will not be renewed. At the end of FY 79, six additional PSROs had been notified that they are serious candidates for termination. The reason for these actions has been mismanagement of Federal funds in some cases, and inadequate performance of PSRO functions in others. These defundings demonstrate HCFA's commitment to positive performance by PSROs as a criterion for continued funding.

Although the extreme action of defunding must be taken in some cases, the major goal is improvement, rather than punishment. Now that PSROs understand that non-renewal of their grants is a serious possibility, those in trouble appear more willing to work to resolve their problems. This will permit HCFA to retain the positive aspects of the organization, while working to improve weaknesses.

The emphasis on efficiency has also highlighted the issue of small PSROs. In many instances, the return per dollar simply is not sufficient. HCFA is pursuing legislative and regulatory changes which would simplify the area redesignation and consolidation process and allow for efficiency to be used as a criterion in consolidating areas. HCFA has also explored the feasibility of consolidating PSRO areas in those instances when a PSRO is terminated for failure to perform. With small PSROs, HCFA has pursued the possibility of voluntarily consolidating with adjacent PSROs, where such a consolidation would result in a more efficient review system. During 1979 one PSRO (Southern Maryland PSRO Inc.) voluntarily withdrew from the program in favor of consolidating its area with an area served by a nearby PSRO.

5. Review Procedures

- PSRO Hospital Ancillary Services Review

The PSRO legislation clearly specifies that PSROs are to review ancillary services, and HCFA intends that PSROs should implement that review as soon as possible. Through ancillary services review, PSROs can enhance the quality of care and also impact on health care costs.

During FY 79, more than 70 PSROs received special initiative funds to develop and implement ancillary service review systems. In addition, other PSROs are undertaking ancillary service review, primarily utilizing the profiling and Medical Care Evalulation processes.

- Physician Services Review

In FY 78 HCFA completed an initiative on PSRO review of physician services that are provided in an institutional setting. This review of services delivered to Medicare and Medicaid beneficiaries involves constructing new relationships between PSROs and Medicare and Medicaid fiscal agents. These directives propose to link Part A denials (hospital day or days) with the review of Part B services (physician services).

In FY 79, physician services review between PSROs and fiscal agents was introduced in five selected areas as demonstration projects.

- Surgical Review

During FY 79, data for calendar years 1973 and 1976 became available on surgical rates for the Medicare population. This data reflects a wide variation in the incidence of surgical procedures. In an effort to analyze these variations, HCFA is involved in several projects:

A. Development and distribution of the Medicare statistical data on surgical utilization to all PSROs.

B. Dissemination of AMA developed sample criteria sets for reviewing the medical necessity of surgical procedures.

C. Initiation and monitoring of a contract for the evaluation of PSRO impact on the quality and utilization of surgical services in five selected PSROs.

- Medical Care Evaluation Studies

PSRO's primary impact on quality is achieved through the Medical Care Evaluation (MCE) process. The most significant activity in the area of MCE studies this year is the development of a new and broader quality review policy.

The earlier policy focused on the conduct of MCE studies as a PSRO review responsibility and was based on hospital size. This policy resulted in steadily increasing numbers of studies being performed by hospitals and PSROs. While the strengths of the MCE study policy fostered interest and development of the program, a primary concern was the over-emphasis on rigid numbers. As a result of this concern, new policy was developed that emphasized quality improvement and impact on patient care. This policy is being implemented in 1980; however, it will remain in draft form for one year in order to provide technical assistance to the PSROs and hospitals and to give the PSROs and hospitals an opportunity to comment on both the benefits and problems of implementation.

- Profile Development

PSROs are required by legislation to develop and analyze practitioner, patient, and institutional "profiles" in order to identify patterns of care. Once a pattern of care has emerged, it is compared to other like institutional patterns. From that comparison, particular tendencies and trends can be identified. To generate profile data a PSRO needs to have both an automated data system and a significant number of reviews completed. Currently, 123 PSROs are reporting profile analysis activities as required, reflecting a 50 per cent increase in the number of PSROs reporting at the same time last year. A number of activities have been undertaken during the last year to promote profile development and analysis among PSROs. Extensive technical assistance has been given to PSROs through various vehicles such as (1) technical assistance documents, (2) use of expert consultants at individual PSROs, (3) symposia, and (4) presentations at the regional offices. An evaluation has been conducted of PSRO activities in profile analysis that indicates the successful characteristics of effective PSRO profiling programs.

- Ambulatory Care Review

Ambulatory care is provided to patients not required to be in an institution. It includes services provided in a physician's office or in an outpatient clinic. The law requires PSROs to commence ambulatory care review two years after they are fully designated. Such review is implemented at the initiative of the PSRO and with the approval of the Secretary.

In FY 79, six demonstration projects were funded to perform review of ambulatory services. Through these demonstrations HCFA has been examining the efficacy and efficiency of various ambulatory review methodologies. Emphasis during FY 79 has been on review of care provided to Shared Health Facilities, sometimes referred to as "Medicaid Mills", where overutilization has been cited as a problem.

The experience gained from these demonstrations will assist HCFA in developing prototypes for broader implementation of ambulatory care review activities in the future.

- Long Term Care (LTC) Review

By the end of FY 79, fifty-five PSROs were funded to conduct review in LTC facilities. PSRO experience in the LTC area is developmental in nature; however, PSROs are attracting personnel interested in health care for individuals with LTC needs and their appropriate placement.

Forty-five of the fifty-five PSROs funded for LTC review are performing pre-admission certification; twenty-two of these areas conduct their reviews in both the community and hospital setting. PSROs performing pre-admission certification have indicated that this process is advantageous to both the patient and facility provider, since it provides for placement in the

appropriate setting, thereby reducing the potential for future relocation, and assuring payment for patient care. Pre-admission certification has become a popular concept within recent years. However, the cost-effectiveness of the approach remains to be carefully studied and documented.

Based on the experience acquired in FY 79, and the Rand Report which evaluated 10 of the original PSRO LTC demonstrations, it is felt that PSROs have potential for demonstrating impact on the quality of care provided to patients in LTC facilities. Mechanisms are being developed to address the unique problems of achieving effective quality review in the LTC setting which differ markedly from the hospital setting. For example, some PSROs are using concurrent quality care check lists that have been developed by LTC Committees to monitor patient care. These check lists focus on the presence of appropriate components in the care provided to patients. Constructive action programs have been undertaken by PSROs to assist LTC facility staff in improving the quality of care available to facility patients.

6. PSRO Impact: The 1979 PSRO Evaluation

The evaluation of the Professional Standards Review Organization, (covering calendar year 1978) is the third in a series. The evaluation reveals that for the second consecutive year, PSROs have reduced Medicare hospital utilization relative to inactive PSRO areas, and the PSRO Medicare concurrent review activity continues to pay for itself. PSROs showed a 1.1 benefit-cost ratio for 1977, and in 1978 analysis disclosed a 1.269 ratio.

The major utilization study in FY 79 demonstrated that PSRO impact is not uniform across the nation, for reasons which are not yet fully understood. For example, the northeast section of the country shows a 4.8 per cent decrease in the days of care per thousand patients, the north central section a 2.1 per cent decrease in days of care per thousand, and the west a 1.4 per cent decrease, while the south demonstrated a 3.7 per cent increase in days of care per thousand. HCFA will continue to work to identify the factors that contribute to PSRO effectiveness.

The FY 79 evaluation presents the first major study of PSRO impact on physician compliance with quality of care criteria. The study shows that medical care evaluations (MCEs) can and do identify variations in quality care. When PSROs identify variations from accepted standards, compliance with those standards improves significantly over time. Preliminary work on the benefit-cost analysis of MCEs indicates the potential for considerable cost benefits resulting from improvements in the quality of care.

End-Stage Renal Disease Medical Review Boards

End-Stage Renal Disease Medical Review Boards (ESRD/MRBs) have quality assurance functions similar to PSRO's. However, ESRD/MRBs review a special Medicare population over a much larger geographic area -- the ESRD network area. There are 32 designated network areas. Most MRB review of Medicare ESRD patients is done for the ambulatory dialysis setting. Review of care which is provided in the hospital is coordinated with the PSRO in whose area the

hospital lies. ESRD/MRBs monitor the appropriateness of patients' treatment procedures; review the comparative performance of facilities and physicians with regard to patient care; and assure quality of care by conducting medical care evaluation studies and other in-depth studies.

During FY 79, the first full year of operation for some MRBs, most of the Medical Review Boards were engaged in conducting medical care evaluation (MCE) studies. The topics of the MCEs varied as the MRBs responded to local needs. At this time, the levels of experience and review sophistication of MRBs vary and some of the studies conducted must be considered rudimentary. As the MRBs gain experience with the process, the studies will become more sophisticated and will be aimed at more complex problems.

Special studies were conducted where problems were uncovered that did not adapt easily to the MCE format. In some areas, the MRBs have been thoroughly established as experts on renal related matters and have responded with technical assessment to a host of inquirers on quality related issues.

In order to assist MRBs carry out their review responsibilities more effectively, HCFA funded a contract in FY 79 to develop technical guidance for MRBs. This guidance will include (1) designing a quality assurance process, (2) providing methodologies for ESRD facility and physician profiling, MCEs, and special studies, and (3) developing a clearinghouse for network quality assurance activities. This contract will be completed in FY 80.

Second Surgical Opinion Program

In addition to PSRO medical review activities related to unnecessary surgery, as part of an overall strategy to deal with this problem the Department initiated a voluntary second surgical opinion program. In FY 78, HCFA began a major consumer information campaign to encourage all Americans - and particularly the Medicare and Medicaid beneficiaries - to seek a second opinion before undergoing non-emergency surgery. The campaign is premised on the patient's right to know the benefits and risks of the recommended surgery and any alternatives to that surgery.

HCFA's second surgical opinion program centers around two major efforts: a national second opinion referral system and a public information campaign. In 1978, nearly 4 million brochures entitled, "Facing Surgery? Why Not Get a Second Opinion?" were distributed throughout the United States. Articles were prepared for a number of major periodicals. In July 1979, a message encouraging Social Security beneficiaries to seek second opinions was enclosed with the beneficiary check.

Patients wishing second opinions can contact local referral centers or call a national toll-free number to obtain the name and phone number of their local referral center. During FY 79, approximately 13,500 calls were made to the National Hotline and about 7,400 calls to local referral centers. Calls increased substantially after each public information campaign effort.

In addition, HCFA funded two demonstration projects, described in greater detail in Chapter III, in the New York City and Detroit metropolitan areas. Both demonstrations provide free second opinion (and third opinion) resources for over 2 million Medicare beneficiaries. These two programs are being evaluated by an independent contractor to determine the impact of the demonstration programs on surgery rates and costs, and the health care effects of non-surgical treatment where the surgical alternative has been deferred or abandoned.

F. INCREASING HMO ENROLLMENT BY MEDICARE BENEFICIARIES

Health Maintenance Organizations (HMOs) represent an alternative to traditional health care delivery mechanisms. Essentially, HMOs combine the insurance function with the provision of all Medicare services. Under a single organizational structure, HMOs provide care either by (1) directly employing or owning the necessary personnel and facilities, or by (2) purchasing, or otherwise arranging for, the covered services. The entire range of services is purchasable by HMO members through a regular premium payment, which insures the member against the costs of any care furnished through the HMO. Thus, HMOs are both providers of care and insurers of care. Since the costs of care are prepaid by the HMO member, considerable incentive exists for the HMO to provide only such care as is medically necessary, to avoid hospitalization and other expensive institutional care whenever possible and, emphasizing preventive care.

In view of the potential for significant cost savings to the Medicare program, the Congress, in 1972, authorized Medicare to enter into contracts with qualified HMOs. Congress authorized reimbursement through a single monthly capitation payment for all covered services, both Part A and B, furnished to beneficiary enrollees. Previously, prepayment plans such as HMOs could be reimbursed on a capitation basis only for the costs of providing physicians' and related services under Part B.

At the end of 1977, Medicare was paying eight HMOs under the new provisions. By the end of 1978, there were 23 HMOs under Medicare contract. As of December 31, 1979, there were approximately 42,000 Medicare enrollees and 31 HMO Medicare contracts.

During 1979, the Health Care Financing Administration continued its emphasis on beneficiary enrollment in HMOs. Over 3,700,000 beneficiaries living in HMO service areas were notified by mail of the availability of HMO services. The Bureau has also actively encouraged all qualified HMOs to enter into contracts to provide Medicare services. Medicare enrollment in HMOs is expected to grow substantially in the next few years.

In June 1979, the Administration proposed legislation to change the method for Medicare reimbursement of HMOs. The Administration's proposal embodies two fundamental changes to current policy. First, Medicare would pay HMOs a prospectively determined fixed amount for each enrolled beneficiary, rather than an interim capitation rate subject to retrospective adjustment. This policy is consistent with the way HMOs are paid for private enrollees. Second, enrolled beneficiaries would share in any savings which result from their decision to seek care through a more efficient HMO system. The proposal is designed to use Medicare payments to contain health care costs rather than fueling inflation -- and to do so through competitive rather than regulatory measures. Under the proposal, Medicare would pay the HMO a prospective rate equal to 95 per cent of the amount Medicare estimates it would pay if the HMO Medicare members were to receive fee-for-service care. The HMO would also be required to calculate prospectively a Medicare rate based on a "community rating system", but adjusted for differences in utilization of services by Medicare beneficiaries and private members of the HMO. If the HMO's average premium for private members (adjusted for Medicare benefits and utilization rates) is lower than the 95 per cent of the fee-for-service equivalent, the difference must be used to finance broader benefits or to reduce cost sharing for its Medicare members.

G. FRAUD AND ABUSE CONTROL ACTIVITIES

Fraud and abuse control is a critical administrative activity in respect to the Medicare program. Medicare beneficiaries and the tax paying public who share in the cost of the program must be assured that the program is being operated efficiently, so that their tax and contribution dollars are not being wasted. The financial magnitude of the program invites fraud and abuse and imposes intense management responsibilities in developing effective methods for assuring program integrity. The Health Care Financing Administration is responsible for activities to control fraud and abuse in the Medicare program. In order to fulfill that responsibility, HCFA performs the following functions:

1. Conducts and monitors comprehensive reviews of selected providers which reveal indications of potential fraud, abuse, waste, or misapplication of policies;

2. Reviews selected areas of program reimbursement for evidence of potentially wasteful policies or procedures;

3. Directs administrative sanctions efforts against practitioners and providers showing potential fraud, abuse, or waste; and

4. Initiates actions, or refers for appropriate legal or financial action, in those cases where inappropriate payments have been made.

Current Status and Results

In carrying out the responsibilities outlined above, HCFA's activities resulted in:

1. Workload FY 79

*Integrity Reviews

Received:	25,028
Cleared:	24,587
**EOY Pending:	8,355

Full-Scale Abuse

Received:	3,352
Cleared:	2,877
EOY Pending:	1,761

Full-Scale Fraud

Received:	515
Cleared:	526
***RF to USAT:	259
Convictions:	44
EOY Pending:	645

Number of Cased Referred to Office of Investigations: 216

*Includes Contractors' Receipts
**End of Year Pending
***Referred to U.S. Attorney

2. Sanctions - In FY 79, action was taken to suspend (under Section 1862(e) of the Act) 46 physicians/practitioners from participation in the Medicare program as a result of their conviction of a criminal offense related to their involvement in the Medicare or Medicaid program. The length of the suspension periods ranged from 1 year to 10 years. Action was taken to withdraw the suspensions or to reinstate a previously suspended physician/practitioner in 22 cases. Exclusion actions (under Section 1862(d) of the Act) were taken on 16 providers, practitioners, and/or other suppliers of health care services. The Secretary has taken termination action against three providers (1 hospital and 2 nursing homes) under Section 1866 of the Act.

3. Payment Review (PARE) - The ninth annual payment review project was conducted during 1979. This program identified physicians/ suppliers whose services generated $25,000 or more in program payments ($15,000 or more to podiatrists and $5,000 or more to chiropractors) and whose pattern of practice, when compared to their peers, revealed a variance which required a review for potential fraud or program abuse. During 1979, approximately 3,500 reviews were completed. These reviews disclosed a projected overpayment of $2.9 million, resulting in the initiation of recoupment actions by Medicare carriers. In addition, 74 cases were identified for further investigation of possible fraud. Three physicians were referred for consideration of an exclusion sanction under Section 1862(d) of the Act.

4. Program Validation - During FY 79, HCFA intensified its validation review program to detect fraud, abuse, and waste among providers and to identify and correct inappropriate and potentially wasteful policies and procedures. To accomplish this, the validation reviews focused on examination and evaluation of the providers' billing practices, weaknesses in the billing process, methods for determining levels of reimbursement and Medicare policies which may have contributed to inappropriate reimbursement. In 1979, these efforts resulted in the completion of draft or final reports on 24 institutional validation reviews, 20 non-institutional reviews and 5 special reviews. Reports on

15 of these reviews were finalized during FY 79. The reports identified overpayments or other potential program savings, amounting to more than $1.5 million. The draft reports of the remaining 34 reviews revealed potential overpayment or savings of more than $8 million. Based on the experience gained thus far, HCFA will be modifying and re-defining procedures used to target providers and highlight other areas for review.

5. Overpayments and Savings - The Medicare overpayment identified in FY 79 totaled $9,378.00. (That figure includes $2.5 million of the $9.5 million identified in the program validation review program.)

   Savings resulting from systems and procedural changes for contractor inspection and evaluation program and validation reviews was $1,199,000 in FY 79.

   The projected value of deterrents resulting from HCFA's validation activities in FY 79 was $6,222,000.

Future Activities

1. Home Health Benefits - To address problems identified in FY 79 in the home health benefits program, several significant initiatives are being undertaken in FY 80. They include:

   a. intensified audit activities by intermediaries to closely examine costs of operation and necessity of home health services;

   b. formation of program validation teams to perform investigative audits in five States;

   c. referral of questionable not-for-profit home health agencies to the IRS for redetermination; and

   d. development of a more detailed management reporting system.

2. Podiatry Services - In FY 80, HCFA is planning a review of podiatry services in selected locales. The review is designed to (a) validate that the services billed for were actually provided by reviewing the provider's medical records; (b) evaluate the effectiveness of the carriers' techniques for preventing and identifying program abuse; and (c) evaluate the adequacy of Medicare's guidelines and instructions intended to prevent and identify program abuse.

H. BENEFICIARY SERVICES

The ultimate measure of the Medicare program lies in whether its organizational structure, policy decisions, and procedural mechanisms are comprehensible to and usable by program beneficiaries. If these criteria are met, beneficiaries can secure all the benefits to which the program entitles them. The Medicare program has always engaged in an extensive informational activity directed primarily to beneficiaries. Information has also been directed to the health care community to enable them to help the beneficiary understand the program and the claims submittal process. These informational activities have centered around the dissemination of a broad array of written materials, considerable use of the media, placement of messages in newspapers and magazines, and preparation of radio and TV programming materials.

There are some limits, however, to what these general informational services can achieve for beneficiaries to assure that they effectively use program mechanisms to obtain full program benefits. First, Medicare program provisions and procedures are often very complex. Additionally, the primary Medicare audience is elderly. They represent a population group which did not always attain the same level of education as later generations. Also, the cultural conditioning of two generations ago does not result in as aggressive a pursuit of individual rights as is characteristic of succeeding generations. Thus, written material directed to the general Medicare population does not always carry the same assurance of behavioral impact as written campaigns directed to younger audiences. All too often, Medicare beneficiaries are not sufficiently informed to act appropriately and timely in order to secure their program rights.

In addition, all health insurance programs, whether public or private, share the problem of educating enrollees about program benefits. Most individuals who receive information only respond when it is relevant to their present needs. Even among the elderly Medicare population, who utilize health care services at a rate approximately three times those under age 65, the receipt of health care services is episodic and infrequent. The average Medicare beneficiary from attainment of age 65 until death, will be a hospital patient about 3 1/2 times. The average Medicare beneficiary will see a physician seven times a year. Additionally, their use of skilled nursing facility services, home health services, ambulance services, prosthetic devices and other covered Medicare services will be extremely limited. Individuals who are currently well usually decide to wait until the need for care arises before coping with explanatory materials that describe coverage and procedures for securing benefits.

Therefore, the Medicare program made substantial efforts to locate program informational materials at places where medical services are rendered; e.g., hospitals, physician offices, and clinics. While this emphasis has almost certainly increased the accessibility of program information, the factor of beneficiaries' preoccupation with their medical needs reduces the effectiveness of these measures. At that time, they are not primarily interested in the post-illness aspect of Medicare reimbursement.

HCFA recognized these limitations in informational effectiveness, and took several actions to enhance beneficiary access to program information or assistnace, when needed.

Establishment of Office of Beneficiary Services - In order to create a high-level focus for beneficiary service improvement within HCFA, the Office of Beneficiary Services was established. A formal proposal was approved by the Secretary and was published in the Federal Register on December 21, 1979.

Improving Beneficiary Access to Medicare Carriers - Since the inception of Medicare, Social Security offices have been the primary direct assistance resource to beneficiaries. This reflected traditional patterns of service to Social Security program beneficiaries since 1937, when Social Security benefits became payable. However, because the claims decision process under the Medicare program was assigned to private insurance organizations (intermerdiaries and carriers) rather than to Social Security offices, these offices were not totally prepared to service Medicare beneficiaries. It became increasingly evident from a number of studies that, in respect to medical insurance claims inquiries, the Social Security office referred the beneficiary to the Medicare carrier for information regarding the inquiry. (Beneficiary inquiries under the hospital insurance program are far less frequent since the hospital insurance claims process does not directly involve the beneficiary. It is essentially a transaction between the provider of services and the intermediary.) A determination was made that approximately 90 per cent of the entire Medicare inquiry workload directed to Social Security offices involved the need for information about a medical insurance claim either in process or already adjudicated by the Medicare carrier. The bulk of this inquiry workload involved the Social Security office as a transmitting mechanism to the carrier, rather than as a direct beneficiary service resource.

In FY 78, HCFA decided that the medical insurance claims inquiry workload should be handled by the Medicare carriers as a direct service to beneficiaries. HCFA reasoned that the carrier had immediate access to the claims record and could provide a more prompt and responsive service if they were the point of initial contact by the beneficiary. Because the carrier function is generally located at a single site within a State, physical access was only possible for beneficiaries living within the immediate vicinity of the carrier. In order to accomplish a direct beneficiary service capability, HCFA decided that the development of toll free telephone service to the carrier could provide the necessary cost-free, direct beneficiary service capability that would make program responsiveness to the beneficiary more effective and more timely.

At the end of FY 79, toll free telephone service had been established either partially or completely at all carrier locations. Each carrier is generating extensive publicity to identify the availability of toll free service. Social Security offices are advising beneficiaries of this change during personal and correspondence contacts. The performance of carriers in this direct beneficiary servicing area is being closely monitored. HCFA wants to assure that beneficiaries suffer no loss of service effectiveness as a result of this reassignment of responsibility.

Beneficiary Aide Program - In Fy 79, HCFA continued to expand beneficiary aide programs. In collaboration with the National Council of Senior Citizens, the American Association of Retired Persons and Area Agencies on Aging, 118 projects have been developed in various parts of the country. Volunteers, primarily drawn from program beneficiaries, are trained to act as peer counselors. They provide information about Medicare and assist in preparation of claims forms.

Toward the end of FY 79, HCFA began planning to include the Retired Seniors Volunteer Program (RSVP) in the beneficiary aide program. Funding has been authorized for one pilot project in each of the 10 DHEW regions during FY 80.

Medi-Gap - Medicare coverage, while very substantial, is not comprehensive. With respect to the services the program covers, there are deductible and coinsurance amounts for which beneficiaries remain liable. Therefore, the private insurance industry has marketed a wide variety of supplementary health insurance policies, usually called "Medi-Gap" coverage. In hearings held by the Senate Special Committee on Aging and the House Select Committee on Aging in 1978, substantial evidence indicated that a number of the elderly were being taken advantage of in the purchase of such policies. Evidence was introduced which revealed that some insurers misrepresented themselves as being Government representatives. Some insurers were selling an excessive number of policies that were not only duplicative but offered little additional protection toward expenses not covered by Medicare. Many insurers were selling policies in which a number of "fine print" features substantially precluded payment of benefits for a wide range of illnesses. Because it was evident that much abuse was attributable to unawareness on the part of purchasers as to the relationship between Medicare and various "Medi-Gap" policies, it was decided that, although this was an area of commerical transaction generally within the regulatory jurisdiction of State insurance departments, the Medicare program had a special responsibility to assist its beneficiaries to understand their Medicare coverage and what additional protection they might need.

In collaboration with the National Association of Insurance Commissioners, a pamphlet "Guide to Health Insurance for People with Medicare" was issued in September 1979. The brochure describes Medicare coverage in relation to private insurance supplements. It also offers a number of guides to help beneficiaries make judicious choices and avoid unscrupulous marketing practices by some insurers. The pamphlet has been exceedingly well received. HCFA is now developing a "Medi-Gap" training program to be implemented in FY 80. It will be directed to public interest groups who will work with HCFA to develop a network of advisory resources to beneficiaries throughout the United States.

Research and experimentation in support of the Medicare program is authorized under the Social Security Act Amendments of 1965, 1967, 1972, and 1977 and under the National Health Planning and Resources Development Act of 1974. Within the Health Care Financing Administration (HCFA), the Office of Research, Demonstrations, and Statistics (ORDS) studies and develops ways to promote efficiency and quality within Medicare and other HCFA programs. ORDS assesses the impact of HCFA programs on health care costs, program expenditures, beneficiary access to services, health care providers, and the health care industry. Research and demonstrations conducted by ORDS test and evaluate alternatives to present reimbursement, coverage, eligibility, and management policies of the current Federal programs.

In FY 79 ORDS conducted research and demonstration projects in the following ten program areas:

- o Beneficiary Impact
- o Fraud and Abuse
- o Health Systems Organization
- o Hospital Costs
- o Industrial Organization
- o Integrated Data Systems
- o Long Term Care
- o Physician Reimbursement
- o Program Evaluation
- o Quality and Effectiveness

Although projects are conducted on all HCFA programs under these ten areas, only those related to Medicare are described in this report. Additional information on HCFA research and demonstration projects can be obtained from the HCFA monograph Health Care Research and Demonstration Projects.

Beneficiary Impact

HCFA reports and analyzes statistics on Medicare beneficiaries, the program expenditures on their behalf, their patterns of service use, and the characteristics of health care providers servicing them. Using data from Medicare administrative records, ORDS researchers can assess the use and cost of Medicare benefits, determine whether services have been provided efficiently, and evaluate Medicare's role in improving access to care for aged and disabled.

In 1979, ORDS researchers and statisticians developed new capabilities for analysis by creating two special data files from existing administrative records: the Continuous Medicare History Sample (CMHS) and the second edition of the Medicare Provider Analysis and Review (MEDPAR-2) file. Because the CMHS file links records of different kinds of Medicare services used by a given Medicare beneficiary over time, it will improve estimates such as the total Medicare costs associated with specific diagnoses. The MEDPAR-2 file gives PSROs and health systems agencies (HSAs) information on the use of hospital services by Medicare beneficiaries in individual hospitals and by geographic area. The PSROs and HSAs can then identify hospitals with substantially different patterns of care than other hospitals in their locality.

In addition to analysis of administrative records, HCFA develops other sources of data on the Medicare program. In 1979 HCFA and the National Center for Health Statistics worked to design the National Medical Care Utilization and Expenditure Survey (NMCUES). This survey will produce new information on the health status and economic resources of Medicare beneficiaries, their use of health services not covered by Medicare, the sources of financing used for uncovered care, and barriers to care. HCFA will use the results to address the unmet health needs of Medicare beneficiaries.

Fraud and Abuse

Public Law 95-142 authorizes the development and demonstration of "improved methods for investigation and prosecution of fraud" under the Medicare and Medicaid programs. Under contract with HCFA in 1979, New York's Office of the Special Prosecutor developed an audit review program for hospitals and compiled a manual of techniques for investigation and prosecution of criminal violations. ORDS researchers worked with Medicare program staff to develop sampling guidelines that intermediaries and carriers could use to estimate overpayments to physicians and other Medicare providers.

Health Systems Organization

Projects within this program area seek to improve the access of Medicare beneficiaries to health services and, at the same time, provide incentives to keep costs to a minimum. Some studies explore alternative approaches to the organization and delivery of health care while others modify payment methods for current health care institutions and practitioners.

In FY 79 HCFA supported a series of demonstrations in health maintenance organizations (HMOs) and urban clinics. The HMO demonstrations tested incentives for enrollment of Medicare beneficiaries and reimbursement methods that would reduce Medicare benefit costs. Due to their potential for cost savings, HMOs could offer extra benefits or reduced cost-sharing to beneficiaries and yet contract with Medicare at a rate lower than the average fee-for-service cost. In collaboration with the Robert Wood Johnson Foundation, HCFA began demonstrations to determine whether primary care clinics affiliated with municipal outpatient departments could improve access to care and contain costs in urban areas. For these clinics, the Medicare program waives co-payments and deductibles and reimburses primary care and preventive services not covered by Medicare. Other health systems projects in 1979 included demonstrations of extended Medicare mental health benefits, analyses of the impact of physician extenders, and demonstrations covering home health aides and family helpers for end-stage renal disease patients.

Hospital Costs

During fiscal year 1979 approximately $76 billion was spent on hospital care. Medicare paid $19.1 billion or 25 per cent of this total for the provision of hospital care to its beneficiaries. This is about a 13 per cent increase over the previous year. ORDS conducts an extensive research and demonstration program designed to contain hospital costs at the lowest level while continuing to provide quality care. In FY 79 ORDS' economic studies continued to define the basic components of hospital costs, isolate the factors that influence them, and explain the variations in costs among similar institutions. The findings from these studies have enabled ORDS to develop Medicare reimbursement controls that would identify more precisely the cost differences among hospitals due to differences in patient mix. These controls would also place prospective limits on total hospital costs as opposed to routine operating costs.

In addition to efforts to design Federal reimbursement controls to contain hospital costs, HCFA has supported demonstrations of State and regional programs to set hospital rates or approve hospital budgets. In the States of Maryland and Washington HCFA has waived Medicare reimbursement principles in order to test the impact of State rate setting programs. Seven other programs funded by HCFA worked to develop rate-setting methods for future experiments. Under contract, HCFA undertook a three-year evaluation of State and regional rate-setting programs, including initiatives without Federal funding. This evaluation will trace the costs and savings of each program as well as their effects on the composition and availability of hospital services, quality of care, and substitution of medical services rendered outside hospitals.

Industrial Organization

HCFA supports research into the effects of Medicare and Medicaid reimbursement policies on various health industries, including medical equipment and supplies, clinical laboratories, drugs, and health insurance. Studies consider the market structure and performance of each industry and the relationship of suppliers to hospitals and other health care providers. One such project in 1979 investigated the effects of coverage by Medicare and other insurers on the price, frequency, and location of laboratory tests. ORDS grants also supported studies of hospital purchasing practices and alternative Medicare reimbursements for durable medical equipment.

Integrated Data Systems

HCFA supports the development of uniform systems to collect and process data on billing, discharges, use of services, and costs from hospitals and other institutions participating in Medicare and Medicaid. Such systems will help the Medicare program to reimburse for services on the basis of comparable cost data, to assess alternative payment methods, and to identify fraud, abuse and error. Institutions participating in Medicare will benefit from elimination of overlapping and duplicative reporting requirements, replacement of paper transactions with automated process, and easier dissemination of data to multiple Federal, State and local users.

During FY 79 HCFA continued to develop a system to collect uniform cost and utilization data from hospitals based on functional cost centers. Proposed regulations for the Annual Hospital Report (formerly known as the System for Hospital Uniform Reporting) were published in January 1979. HCFA has since

revised the reporting forms and manual and has completed a study of the costs of the proposed system to the hospital industry. HCFA also began in 1979 to develop a system that would combine uniform reporting and Medicare cost reports for home health agencies.

HCFA expanded its efforts in FY 79 to develop model integrated data systems to collect, process, and merge uniform discharge, billing, and cost data from hospitals. In addition to an on-going experiment in New York State, ORDS made new grants in 1979 for demonstrations of six model systems.

Long-Term Care

HCFA supports research and demonstrations in long-term care for the growing numbers of the elderly, the disabled and the chronically ill. In FY 79 this program area encompassed studies of the populations in need of care, the factors affecting choice on different kinds of care, the effects of changes in public funding of services outside institutions, the economics of the long-term care industry, and methods to reimburse nursing homes prospectively. HCFA also funded demonstrations of community systems that provide elderly clients with obtaining services, and monitoring of the appropriateness of services.

In FY 79 HCFA selected 26 sites to conduct a demonstration to cover hospice services to the terminally ill. The evaluation of this demonstration will compare the kinds and costs of services available to the terminally ill through hospices and in conventional settings already reimbursed by Medicare. The demonstration will be funded after Medicare and Medicaid waivers are approved for reimbursement of hospice services. Another current demonstration that affects long-term care coverage under Medicare waives the requirement for hospitalization prior to admission to a skilled nursing facility.

Physician Reimbursement

Medicare finances almost one sixth of national expenditures for physician services. To develop a sound base for policy decisions on physician reimbursement, HCFA supports research into the costs and patterns of physicians' practices, physician prices and incomes, and participation in financing programs. In February 1979, ORDS held its first annual conference on physician reimbursement to discuss the policy implications of the results of these descriptive and behavioral studies.

HCFA's data bases on physicians make possible the design of alternative reimbursement methods, such as fee schedules and service packages, and the simulation of their effects on the Medicare program. Information collected on practice costs and productivity directly contributes to the refinement of the Medicare economic index, the only current means to restrain Medicare payments for physician fees. Studies on physician participation in the Medicare program have supported the development, in 1979, of "assignment" demonstrations to encourage physicians to accept Medicare reimbursement rates as payment in full. These demonstrations also include elements to enhance professional relations, increase beneficiary education, and improve administration.

Program Evaluation

HCFA conducts research to measure the performance of agency programs and to suggest legislative or administrative improvements. In FY 79, HCFA examined the Professional Standards Review Organization (PSRO) program and the Maximum Allowable Cost for Drugs program. The 1979 PSRO evaluation refined and updated earlier analyses on the effect of PSRO activities on the Medicare program. One part of the evaluation examined regional variations of the effect of PSROs on days of inpatient hospital care for Medicare beneficiaries. A second part tested the hypothesis that PSROs are more likely to reduce Medicare hospital use associated with certain diagnoses or surgical procedures. A pilot study of a limited number of PSROs examined whether PSROs change the mix of Medicare cases treated in the hospital. The 1979 evaluation also included cost-benefit analyses of the PSRO program, studies of PSRO medical care evaluation activities, and descriptions of PSRO program status and organizational characteristics. The findings of the 1979 PSRO evaluation will be published in Spring 1980.

Quality and Effectiveness

HCFA develops and evaluates methods to determine whether Medicare beneficiaries receive appropriate, high quality care. ORDS research on malpractice led in 1979 to a proposed HCFA regulation reapportioning Medicare reimbursement for hospital malpractice insurance costs. By relating Medicare reimbursement to the hospitals' risk of malpractice awards to Medicare beneficiaries, the new regulations will save Medicare an estimated $270 million a year. During FY 79, HCFA awarded a major contract to evaluate experimental Medicare second opinion programs in New York and Michigan along with HEW's nation-wide second opinion initiative and the mandatory Medicaid second opinion program in Massachusetts. This study will not only determine factors affecting the use of second opinion benefits and analyze decisionmaking by physicians and patients, but it will also assess the impact of the program on surgery rates and the health status of participating patients. Other studies in this program area assess utilization review systems and develop methods to identify inappropriate use of hospital care.

APPENDIX

APPENDIX A

PART A --INTERMEDIARIES

Blue Cross Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06156

Cooperative de Seguros de Vida Puerta Rico
P.O. Box 3428 G.P.O.
San Juan, Puerto Rico 00936

Hawaii Medical Service Association
1504 Kapiolani Blvd., P.O. Box 860
Honolulu, Hawaii 96808

Kaiser Foundation Health Plan, Inc.
1956 Webster St.
Room 310-A
Oakland, California 94612

Mutual of Omaha Insurance Company
P.O. Box 456, Downtown Station
Omaha, Nebraska 68101

Nationwide Mutual Insurance Company
P.O. Box 1625
Columbus, Ohio 43216

The Prudential Insurance Company of America
Drawer 471
Millville, New Jersey 08332

The Travelers Insurance Company
One Tower Square
Hartford, Connecticut 06115

PART A - BLUE CROSS PLANS

Blue Cross and Blue Shield of Alabama
450 Riverchase Pkwy. East
Birmingham, Alabama 35298

Blue Cross and Blue Shield of Arizona, Inc.
321 West Indian School Road
P.O. Box 13466
Phoenix, Arizona 85002

Arkansas Blue Cross and Blue Shield, Inc.
601 Gaines Street
Little Rock, Arkansas 72203

Blue Cross of Southern California
P.O. Box 70000
Van Nuys, California 91470

Blue Cross of Northern California
1950 Franklin Street
Oakland, California 94659

Blue Cross and Blue Shield of Colorado
700 Broadway
Denver, Colorado 80273

Blue Cross and Blue Shield of Connecticut, Inc.
370 Bassett Road
North Haven, Connecticut 06473

Blue Cross & Blue Shield of Delaware, Incorporated
201 West 14th Street
Wilmington, Delware 19899

Group Hospitalization, Inc.
550 12th St., S.W.
Washington, D.C. 20024

Blue Cross of Florida, Inc.
P.O. Box 1798
Jacksonville, FLorida 32201

Blue Cross and Blue Shield of Georgia/Atlanta, Inc.
3348 Peachtree Road, N.E., P.O. Box 4445
Atlanta, Georgia 30302

Blue Cross of Georgia/Columbus, Inc.
2357 Warm Springs Road
P.O. Box 7368
Columbus, Georgia 31908

Blue Cross of Idaho Health Service, Inc.
1501 Federal Way
P.O. Box 7408
Boise, Idaho 83707

Health Care Service Corporation
233 North Michigan Avenue
Chicago, Illinois 60601

Mutual Hospital Insurance, Inc.
120 West Market Street
Indianapolis, Indiana 46204

Blue Cross of Iowa
Ruan Building, 636 Grand Avenue
Des Moines, Iowa 50307

Blue Cross of Western Iowa and South Dakota
Third and Pierce Streets
Sioux City, Iowa 51102

Blue Cross of Kansas, Inc.
1133 Topeka Boulevard
P.O. Box 239
Topeka, Kansas 66601

Blue Cross and Blue Shield of Kentucky, Inc.
9901 Linn Station Road
Louisville, Kentucky 40223

Louisiana Health Service & Indemnity Company
P.O. Box 15699
Baton Rouge, Louisiana 70895

Associated Hospital Service of Maine
110 Free Street
Portland, Maine 04101

Blue Cross of Maryland, Inc.
700 East Joppa Road
Towson, Maryland 21204

Blue Cross of Massachusetts, Inc.
100 Summer Street
Boston, Massachusetts 02106

Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

Blue Cross and Blue Shield of Minnesota
3535 Blue Cross Road
St. Paul, Minnesota 55765

Blue Cross & Blue Shield of Mississippi, Inc.
P.O. Box 1043
Jackson, Mississippi 39205

Blue Cross of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Blue Cross Hospital Service, Inc. of Missouri
4444 Forest Park
St. Louis, Missouri 63108

Blue Cross of Montana
3360 10th Ave., South
P.O. Box 5017
Great Falls, Montana 59403

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248, Main Post Office Station
Omaha, Nebraska 68103

New Hampshire-Vermont Health Service
Two Pillsbury Street
Concord, New Hampshire 03306

Hospital Service Plan of New Jersey
33 Washington Street
Newark, New Jersey 07102

New Mexico Blue Cross & Blue Shield, Inc.
12800 Indiana School Rd., N.E.
Albuquerque, New Mexico 87112

Blue Cross of Northeastern New York, Inc.
P.O. Box 8650
Albany, New York 12208

Blue Cross of Western New York, Inc.
Blue Cross Bldg., 298 Main Street
Buffalo, New York 14202

Blue Cross and Blue Shield of Greater New York
622 Third Avenue
New York, New York 10017

Rochester Hospital Service Corporation
41 Chestnut Street
Rochester, New York 14606

Blue Cross of Central New York, Inc.
P.O. Box 4809, 344 South Warren Street
Syracuse, New York 13221

Hospital Plan, Inc.
5 Hopper Street
Utica, New York 13501

Hospital Service Corporation of Jefferson County
158 Stone Street, P.O. Box 570
Watertown, New York 13602

Blue Cross and Blue Shield of North Carolina
P.O. Box 2291
Durham, North Carolina 27702

Blue Cross of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121

Hospital Care Corporation
1351 William Howard Taft Rd.
Cincinnati, Ohio 45206

Blue Cross of Northeast Ohio
2066 East Ninth Street
Cleveland, Ohio 44115

Blue Cross of Central Ohio
255 East Main
P.O. Box 16526
Columbus, Ohio 43216

Blue Cross of Northwest Ohio
P.O. Box 943
Toledo, Ohio 43656

Blue Cross and Blue Shield of Oklahoma
1215 South Boulder Avenue
Tulsa, Oklahoma 74119

Northwest Hospital Service
100 S.W. Market Street
P.O. Box 1217
Portland, Oregan 97201

Hospital Service Plan of the Lehigh Valley
1221 Hamilton Street
Allentown, Pennsylvania 18102

Capital Blue Cross
100 Pine Street
Harrisburg, Pennsylvania 17101

Blue Cross of Greater Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

Blue Cross of Western Pennsylvania
One Smithfield Street
Pittsburgh, Pennsylvania 15222

Hospital Service Association of Northeastern Pennsylvania
Blue Cross Bldg.
70 North Main Street
Wilkes-Barre, Pennsylvania 18711

Blue Cross of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Blue Cross and Blue Shield of South Carolina
Drawer F, Forest Acres Branch
Columbia, South Carolina 29260

Blue Cross and Blue Shield of Tennessee
Blue Cross Building
Chattanooga, Tennessee 37402

Memphis Hospital Service and Surgical Association, Inc.
P.O. Box 98
Memphis, Tennessee 38101

Group Hospital Service, Inc.
P.O. Box 222146
Dallas, Texas 75222

Blue Cross of Utah
2455 Parley's Way
P.O. Box 30270
Salt Lake City, Utah 84125

Blue Cross of Virginia
2015 Staples Mill Road
P.O. Box 27401
Richmond, Virginia 23279

Blue Cross of Southwestern Virginia
P.O. Box 13047
3959 Electric Road
Roanoke, Virginia 24045

Blue Cross of Washington and Alaska, Inc.
15700 Dayton Ave., North, P.O. Box 327
Seattle, Washington 98111

Blue Cross Hospital Service, Inc.
P.O. Box 1353, Commerce Square
Charleston, West Virginia 25325

Parkersburg Hospital Service, Inc.
P.O. Box 1948
Parkersburg, West Virginia 26101

West Virginia Hospital Service, Inc.
20th and Chapline Streets
Wheeling, West Virginia 26003

Associated Hospital Service, Inc.
401 West Michigan Street, P.O. Box 2025
Milwaukee, Wisconsin 53203

Blue Cross Blue Shield of Wyoming
4000 House Avenue
P.O. Box 2266
Cheyenne, Wyoming 82001

APPENDIX B

PART B - BLUE SHIELD PLANS

Blue Cross and Blue Shield of Alabama
450 Riverchase Parkway, East
Birmington, Alabama 35298

Arkansas Blue Cross and Blue Shield, Inc.
601 Gaines Street
Little Rock, Arkansas 72203

California Physicians' Service
2 Northpoint Street, P.O. Box 7968-Rincon Annex
San Francisco, California 94120

Blue Cross and Blue Shield of Colorado
700 Broadway
Denver, Colorado 80273

Blue Cross & Blue Shield of Delware, Inc.
201 West 14th Street
Wilmington, Delaware 19899

Medical Service of the District of Columbia
550 12th Street, S.W.
Washington, D.C. 20024

Blue Shield of Florida, Inc.
P.O. Box 1798
Jacksonville, FLorida 32231

Mutual Medical Insurance, Inc.
120 West Market Street
Indianapolis, Indiana 46204

Blue Shield of Iowa
Ruan Building, 636 Grand Avenue
Des Moines, Iowa 50307

Blue Shield of Kansas, Inc.
1133 Topeka Boulvard, P.O. Box 239
Topeka, Kansas 66601

Blue Shield of Maryland, Inc.
700 East Joppa Road
Towson, Maryland 21204

Blue Shield of Massachusetts, Inc.
100 Summer Street
Boston, Massachusetts 02106

Blue Cross and Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

Blue Cross and Blue Shield of Minnesota
3535 Blue Cross Road
St. Paul, Minnesota 55765

Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Montana Physicians' Service
404 Fuller Avenue, P.O. Box 4310
Helena, Montana 59601

New Hampshire-Vermont Health Service
Two Pillsbury Street
Concord, New Hampshire 03306

Blue Shield of Western New York, Inc.
15 Chenango Street
Binghamton, New York 13901

Blue Cross and Blue Shield of Greater New York
622 Third Avenue
New York, New York 10017

Blue Shield of North Dakota
4510 13th Ave., S.W.
Fargo, North Dakota 58121

Pennsylvania Blue Shield
P.O. Box 65
Camp Hill, Pennsylvania 17011

Seguros de Servicio de Salud de Puerto Rico, Inc.
GPO Box 3628
San Juan, Puerto Rico 00936

Blue Shield of Rhode Island
444 Westminster Mall
Providence, Rhode Island 02901

Blue Cross and Blue Shield of South Carolina
Drawer F, Forest Acres Branch
Columbia, South Carolina 29219

South Dakota Medical Service, Inc.
1601 West Madison
Sioux Falls, South Dakota 57104

Group Medical and Surgical Service
P.O. Box 222147
Dallas, Texas 75222

Blue Shield of Utah
2455 Parley's Way, P.O. Box 30270
Salt Lake City, Utah 84125

Washington Physicians Service
2401 - 4th Ave., 4th & Battery Bldg. - 6th Floor
Seattle, Washington 98121

Wisconsin Physicians Service Insurance Corporation
P.O. Box 9277
Madison, Wisconsin 53715

PART B - COMMERCIALS, OTHER

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06156

Connecticut General Life Insurance Company
900 Cottage Grove Road
Hartford, Connecticut 06152

E.D.S. Federal Corporation
7171 Forest Lane
Dallas, Texas 75230

The Equitable Life Assurance Society of the
United States
1285 Avenue of the Americas
New York, New York 10019

General American Life Insurance Company
P.O. Box 505
St. Louis County, Missouri 63166

Group Health Incorporated
326 West 42nd Street
New York, New York 10036

Metropolitan Life Insurance Company
One Madison Avenue
New York, New York 10010

Mutual of Omaha Insurance Company
P.O. Box 456, Downtown Stateion
Omaha, Nebraska 68101

Nationwide Mutual Insurance Company
P.O. Box 1625
Columbus, Ohio 43216

Occidental Life Insurance Company of California
P.O. Box 54905, Terminal Annex
12th at Hill Street
Los Angeles, California 90054

Pan-American Life Insurance Company
P.O. Box 60450
New Orleans, Louisiana 70160

The Prudential Insurance Company of America
Drawer 471
Millville, New Jersey 08332

The Travelers Insurance Company
One Tower Square
Hartford, Connecticut 06115

State Agency

Department of Institutions, Social and Rehabilitative Services
P.O. Box 25352, State Capitol Station
Oklahoma City, Oklahoma 73125

APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79) Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

ALL AREAS

BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	27,145,627	HOSPITALS 6,801 GENERAL 6,372 PSYCH. 411 TB 18
MEDICAL INSURANCE	26,374,715	GENERAL BEDS 1,012,139
		SKILLED NURSING FACILITIES 4,963
		BEDS 419,835
		HOME HEALTH AGENCIES 2,788
		INDEPENDENT LABORATORIES 3,373

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$16,731,850,600	INPATIENT HOSPITAL ADMISSIONS	9,541,601	351.5
		SKILLED NURSING FACILITY ADMISSIONS	507,633	18.7
MEDICAL INSURANCE	$ 6,912,382,900	HOME HEALTH VISITS	17,073,000	628.9

ALABAMA

BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	462,577	HOSPITALS 138 GENERAL 135 PSYCH. 3 TB 0
MEDICAL INSURANCE	459,296	GENERAL BEDS 19,437
		SKILLED NURSING FACILITIES 182
		BEDS 12,274
		HOME HEALTH AGENCIES 80
		INDEPENDENT LABORATORIES 31

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$231,640,700	INPATIENT HOSPITAL ADMISSIONS	188,800	408.1
		SKILLED NURSING FACILITY ADMISSIONS	11,400	24.6
MEDICAL INSURANCE	$ 99,448,600	HOME HEALTH VISITS	278,000	601.0

ALASKA

BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	11,299	HOSPITALS 24 GENERAL 23 PSYCH. 1 TB 0
MEDICAL INSURANCE	9,506	GENERAL BEDS 1,069
		SKILLED NURSING FACILITIES 4
		BEDS 207
		HOME HEALTH AGENCIES 1
		INDEPENDENT LABORATORIES 5

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$8,555,000	INPATIENT HOSPITAL ADMISSIONS	3,300	292.1
		SKILLED NURSING FACILITY ADMISSIONS	20	1.8
MEDICAL INSURANCE	$ 3,164,500	HOME HEALTH VISITS	2,000	177.0

* Amount Reimbursed represents amounts paid in calendar year 1978 to, or on behalf of, insured persons.

APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79)
Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

ARIZONA

BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	298,633	HOSPITALS 72 GENERAL 68 PSYCH. 4 TB 0
MEDICAL INSURANCE	290,526	GENERAL BEDS 9,730
		SKILLED NURSING FACILITIES 21
		BEDS 784
		HOME HEALTH AGENCIES 13
		INDEPENDENT LABORATORIES 42

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$167,351,600	INPATIENT HOSPITAL ADMISSIONS	98,000	328.2
MEDICAL INSURANCE	$ 88,165,500	SKILLED NURSING FACILITY ADMISSIONS	3,600	12.1
		HOME HEALTH VISITS	96,000	321.5

ARKANSAS

BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	331,716	HOSPITALS 103 GENERAL 101 PSYCH. 2 TB 0
MEDICAL INSURANCE	327,969	GENERAL BEDS 10,702
		SKILLED NURSING FACILITIES 3
		BEDS 314
		HOME HEALTH AGENCIES 84
		INDEPENDENT LABORATORIES 22

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$140,451,400	INPATIENT HOSPITAL ADMISSIONS	144,900	436.8
MEDICAL INSURANCE	$ 65,381,600	SKILLED NURSING FACILITY ADMISSIONS	700	2.1
		HOME HEALTH VISITS	43,000	129.6

CALIFORNIA

BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	2,487,069	HOSPITALS 561 GENERAL 524 PSYCH. 36 TB 1
MEDICAL INSURANCE	2,463,213	GENERAL BEDS 86,581
		SKILLED NURSING FACILITIES 951
		BEDS 87,821
		HOME HEALTH AGENCIES 126
		INDEPENDENT LABORATORIES 826

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$1,817,315,500	INPATIENT HOSPITAL ADMISSIONS	829,800	333.6
MEDICAL INSURANCE	$ 956,899,300	SKILLED NURSING FACILITY ADMISSIONS	105,100	42.2
		HOME HEALTH VISITS	1,357,000	545.6

* Amount Reimbursed represents amounts paid in calendar year 1978 to, or on behalf of, insured persons.

APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79) Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

COLORADO

BENEFICIARIES		HEALTH CARE RESOURCES					
HOSPITAL INSURANCE	254,506	HOSPITALS	94	GENERAL	89	PSYCH. 5	TB 0
		GENERAL BEDS	11,073				
MEDICAL INSURANCE	248,452	SKILLED NURSING FACILITIES	71				
		BEDS	5,918				
		HOME HEALTH AGENCIES	35				
		INDEPENDENT LABORATORIES	50				

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$144,278,500	INPATIENT HOSPITAL ADMISSIONS	100,600	395.3
		SKILLED NURSING FACILITY ADMISSIONS	4,500	17.7
MEDICAL INSURANCE	$ 64,989,300	HOME HEALTH VISITS	162,000	636.5

CONNECTICUT

BENEFICIARIES		HEALTH CARE RESOURCES					
HOSPITAL INSURANCE	376,316	HOSPITALS	52	GENERAL	44	PSYCH. 8	TB 0
		GENERAL BEDS	12,003				
MEDICAL INSURANCE	370,551	SKILLED NURSING FACILITIES	174				
		BEDS	16,743				
		HOME HEALTH AGENCIES	84				
		INDEPENDENT LABORATORIES	72				

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$245,635,700	INPATIENT HOSPITAL ADMISSIONS	112,100	297.9
		SKILLED NURSING FACILITY ADMISSIONS	17,300	46.0
MEDICAL INSURANCE	$103,292,200	HOME HEALTH VISITS	483,000	1283.5

DELAWARE

BENEFICIARIES		HEALTH CARE RESOURCES					
HOSPITAL INSURANCE	62,928	HOSPITALS	11	GENERAL	9	PSYCH. 2	TB 0
		GENERAL BEDS	2,091				
MEDICAL INSURANCE	61,434	SKILLED NURSING FACILITIES	13				
		BEDS	857				
		HOME HEALTH AGENCIES	6				
		INDEPENDENT LABORATORIES	12				

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$40,112,900	INPATIENT HOSPITAL ADMISSIONS	19,200	305.1
		SKILLED NURSING FACILITY ADMISSIONS	1,100	17.5
MEDICAL INSURANCE	$15,495,500	HOME HEALTH VISITS	52,000	826.3

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APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79)
Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

DISTRICT OF COLUMBIA

BENEFICIARIES		HEALTH CARE RESOURCES				
HOSPITAL INSURANCE	74,038	HOSPITALS	16	GENERAL 14	PSYCH. 2	TB 0
		GENERAL BEDS	4,962			
MEDICAL INSURANCE	71,788	SKILLED NURSING FACILITIES	6			
		BEDS	419			
		HOME HEALTH AGENCIES	4			
		INDEPENDENT LABORATORIES	10			

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$66,271,600	INPATIENT HOSPITAL ADMISSIONS	28,300	382.2
		SKILLED NURSING FACILITY ADMISSIONS	500	6.8
MEDICAL INSURANCE	$31,292,300	HOME HEALTH VISITS	56,000	756.4

FLORIDA

BENEFICIARIES		HEALTH CARE RESOURCES				
HOSPITAL INSURANCE	1,581,795	HOSPITALS	242	GENERAL 221	PSYCH. 20	TB 1
		GENERAL BEDS	47,070			
MEDICAL INSURANCE	1,570,623	SKILLED NURSING FACILITIES	181			
		BEDS	19,416			
		HOME HEALTH AGENCIES	132			
		INDEPENDENT LABORATORIES	130			

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$940,796,300	INPATIENT HOSPITAL ADMISSIONS	570,800	360.9
		SKILLED NURSING FACILITY ADMISSIONS	27,100	17.1
MEDICAL INSURANCE	$536,821,500	HOME HEALTH VISITS	1,427,000	902.2

GEORGIA

BENEFICIARIES		HEALTH CARE RESOURCES				
HOSPITAL INSURANCE	547,774	HOSPITALS	180	GENERAL 169	PSYCH. 10	TB 1
		GENERAL BEDS	24,325			
MEDICAL INSURANCE	544,442	SKILLED NURSING FACILITIES	59			
		BEDS	5,126			
		HOME HEALTH AGENCIES	38			
		INDEPENDENT LABORATORIES	47			

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$251,629,700	INPATIENT HOSPITAL ADMISSIONS	215,700	393.8
		SKILLED NURSING FACILITY ADMISSIONS	6,100	11.1
MEDICAL INSURANCE	$120,599,000	HOME HEALTH VISITS	191,000	348.7

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APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79) Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

HAWAII

BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	73,909	HOSPITALS 25 GENERAL 24 PSYCH. 1 TB 0
		GENERAL BEDS 2,353
		SKILLED NURSING FACILITIES 25
MEDICAL INSURANCE	72,422	BEDS 2,089
		HOME HEALTH AGENCIES 9
		INDEPENDENT LABORATORIES 24

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$40,427,500	INPATIENT HOSPITAL ADMISSIONS	20,400	276.0
		SKILLED NURSING FACILITY ADMISSIONS	1,700	23.0
MEDICAL INSURANCE	$22,412,700	HOME HEALTH VISITS	38,000	514.1

IDAHO

BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	98,360	HOSPITALS 48 GENERAL 48 PSYCH. 0 TB 0
		GENERAL BEDS 2,808
		SKILLED NURSING FACILITIES 41
MEDICAL INSURANCE	95,747	BEDS 3,014
		HOME HEALTH AGENCIES 13
		INDEPENDENT LABORATORIES 8

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$44,871,800	INPATIENT HOSPITAL ADMISSIONS	31,700	322.3
		SKILLED NURSING FACILITY ADMISSIONS	2,200	22.4
MEDICAL INSURANCE	$18,422,000	HOME HEALTH VISITS	77,000	782.8

ILLINOIS

BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	1,305,573	HOSPITALS 274 GENERAL 253 PSYCH. 20 TB 1
		GENERAL BEDS 57,590
		SKILLED NURSING FACILITIES 207
MEDICAL INSURANCE	1,283,174	BEDS 9,327
		HOME HEALTH AGENCIES 122
		INDEPENDENT LABORATORIES 198

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$1,014,215,400	INPATIENT HOSPITAL ADMISSIONS	470,800	360.6
		SKILLED NURSING FACILITY ADMISSIONS	22,500	17.2
MEDICAL INSURANCE	338,925,700	HOME HEALTH VISITS	890,000	681.7

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APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79) Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

INDIANA

BENEFICIARIES	
HOSPITAL INSURANCE	623,020
MEDICAL INSURANCE	607,801

HEALTH CARE RESOURCES					
HOSPITALS	138	GENERAL	128	PSYCH. 10	TB 0
GENERAL BEDS	24,270				
SKILLED NURSING FACILITIES	115				
BEDS	5,957				
HOME HEALTH AGENCIES	43				
INDEPENDENT LABORATORIES	37				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$356,487,900
MEDICAL INSURANCE	$116,840,700

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	220,000	353.1
SKILLED NURSING FACILITY ADMISSIONS	11,100	17.8
HOME HEALTH VISITS	137,000	219.9

IOWA

BENEFICIARIES	
HOSPITAL INSURANCE	407,213
MEDICAL INSURANCE	400,684

HEALTH CARE RESOURCES					
HOSPITALS	156	GENERAL	152	PSYCH. 4	TB 0
GENERAL BEDS	16,499				
SKILLED NURSING FACILITIES	33				
BEDS	819				
HOME HEALTH AGENCIES	96				
INDEPENDENT LABORATORIES	17				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$224,921,600
MEDICAL INSURANCE	$ 72,876,300

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	161,500.	396.6
SKILLED NURSING FACILITY ADMISSIONS	4,200	10.3
HOME HEALTH VISITS	121,000	297.1

KANSAS

BENEFICIARIES	
HOSPITAL INSURANCE	317,980
MEDICAL INSURANCE	312,407

HEALTH CARE RESOURCES					
HOSPITALS	184	GENERAL	177	PSYCH. 7	TB 0
GENERAL BEDS	13,883				
SKILLED NURSING FACILITIES	24				
BEDS	1,702				
HOME HEALTH AGENCIES	51				
INDEPENDENT LABORATORIES	27				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$208,589,200
MEDICAL INSURANCE	$ 73,458,900

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	136,500	429.3
SKILLED NURSING FACILITY ADMISSIONS	2,200	6.9
HOME HEALTH VISITS	86,000	270.5

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APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79)
Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

KENTUCKY

BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	442,315	HOSPITALS 115 GENERAL 109 PSYCH. 5 TB 1
		GENERAL BEDS 15,418
		SKILLED NURSING FACILITIES 92
MEDICAL INSURANCE	438,906	BEDS 4,386
		HOME HEALTH AGENCIES 51
		INDEPENDENT LABORATORIES 35

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$202,663,100	INPATIENT HOSPITAL ADMISSIONS	168,600	381.2
		SKILLED NURSING FACILITY ADMISSIONS	9,400	21.3
MEDICAL INSURANCE	$ 67,000,600	HOME HEALTH VISITS	147,000	332.3

LOUISIANA

BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	425,863	HOSPITALS 151 GENERAL 143 PSYCH. 7 TB 1
		GENERAL BEDS 19,019
		SKILLED NURSING FACILITIES 12
MEDICAL INSURANCE	400,015	BEDS 1,838
		HOME HEALTH AGENCIES 76
		INDEPENDENT LABORATORIES 49

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$216,130,600	INPATIENT HOSPITAL ADMISSIONS	169,900	399.0
		SKILLED NURSING FACILITY ADMISSIONS	2,200	5.2
MEDICAL INSURANCE	$ 77,432,800	HOME HEALTH VISITS	402,000	944.0

MAINE

BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	152,624	HOSPITALS 57 GENERAL 55 PSYCH. 2 TB 0
		GENERAL BEDS 4,546
		SKILLED NURSING FACILITIES 18
MEDICAL INSURANCE	150,625	BEDS 609
		HOME HEALTH AGENCIES 18
		INDEPENDENT LABORATORIES 2

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$90,637,100	INPATIENT HOSPITAL ADMISSIONS	53,400	349.9
		SKILLED NURSING FACILITY ADMISSIONS	1,500	9.8
MEDICAL INSURANCE	$31,787,800	HOME HEALTH VISITS	139,000	910.7

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APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79) Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

MARYLAND

BENEFICIARIES	
HOSPITAL INSURANCE	397,248
MEDICAL INSURANCE	386,372

HEALTH CARE RESOURCES					
HOSPITALS	71	GENERAL	63	PSYCH. 7	TB 1
GENERAL BEDS	14,084				
SKILLED NURSING FACILITIES	77				
BEDS	6,930				
HOME HEALTH AGENCIES	27				
INDEPENDENT LABORATORIES	61				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$305,224,100
MEDICAL INSURANCE	$113,185,700

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	120,200	302.6
SKILLED NURSING FACILITY ADMISSIONS	6,600	16.6
HOME HEALTH VISITS	204,000	513.5

MASSACHUSETTS

BENEFICIARIES	
HOSPITAL INSURANCE	753,235
MEDICAL INSURANCE	741,520

HEALTH CARE RESOURCES					
HOSPITALS	171	GENERAL	156	PSYCH. 13	TB 2
GENERAL BEDS	32,969				
SKILLED NURSING FACILITIES	118				
BEDS	6,650				
HOME HEALTH AGENCIES	148				
INDEPENDENT LABORATORIES	116				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$615,062,600
MEDICAL INSURANCE	$206,024,500

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	263,500	349.8
SKILLED NURSING FACILITY ADMISSIONS	9,600	12.7
HOME HEALTH VISITS	830,000	1,101.9

MICHIGAN

BENEFICIARIES	
HOSPITAL INSURANCE	994,913
MEDICAL INSURANCE	978,063

HEALTH CARE RESOURCES					
HOSPITALS	233	GENERAL	220	PSYCH. 13	TB 0
GENERAL BEDS	39,485				
SKILLED NURSING FACILITIES	281				
BEDS	22,193				
HOME HEALTH AGENCIES	58				
INDEPENDENT LABORATORIES	152				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$774,263,200
MEDICAL INSURANCE	$282,814,800

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	343,100	344.9
SKILLED NURSING FACILITY ADMISSIONS	25,100	25.2
HOME HEALTH VISITS	400,000	402.0

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Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79)
Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

MINNESOTA

BENEFICIARIES		HEALTH CARE RESOURCES				
HOSPITAL INSURANCE	498,178	HOSPITALS	190	GENERAL 183	PSYCH. 7	TB 0
		GENERAL BEDS	21,750			
MEDICAL INSURANCE	491,564	SKILLED NURSING FACILITIES	89			
		BEDS	5,241			
		HOME HEALTH AGENCIES	83			
		INDEPENDENT LABORATORIES	23			

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$313,230,900	INPATIENT HOSPITAL ADMISSIONS	204,100	409.7
		SKILLED NURSING FACILITY ADMISSIONS	7,500	15.1
MEDICAL INSURANCE	$107,756,800	HOME HEALTH VISITS	155,000	311.1

MISSISSIPPI

BENEFICIARIES		HEALTH CARE RESOURCES				
HOSPITAL INSURANCE	308,961	HOSPITALS	118	GENERAL 118	PSYCH. 0	TB 0
		GENERAL BEDS	12,024			
MEDICAL INSURANCE	306,386	SKILLED NURSING FACILITIES	13			
		BEDS	546			
		HOME HEALTH AGENCIES	127			
		INDEPENDENT LABORATORIES	22			

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$147,305,700	INPATIENT HOSPITAL ADMISSIONS	136,500	441.8
		SKILLED NURSING FACILITY ADMISSIONS	600	1.9
MEDICAL INSURANCE	$ 58,230,600	HOME HEALTH VISITS	455,000	1,472.7

MISSOURI

BENEFICIARIES		HEALTH CARE RESOURCES				
HOSPITAL INSURANCE	685,795	HOSPITALS	181	GENERAL 173	PSYCH. 8	TB 0
		GENERAL BEDS	29,359			
MEDICAL INSURANCE	672,648	SKILLED NURSING FACILITIES	49			
		BEDS	3,897			
		HOME HEALTH AGENCIES	47			
		INDEPENDENT LABORATORIES	84			

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$443,827,600	INPATIENT HOSPITAL ADMISSIONS	248,200	414.4
		SKILLED NURSING FACILITY ADMISSIONS	7,200	10.5
MEDICAL INSURANCE	$133,846,000	HOME HEALTH VISITS	669,000	975.5

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APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79) Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

MONTANA

BENEFICIARIES	HEALTH CARE RESOURCES
HOSPITAL INSURANCE 90,504	HOSPITALS 65 GENERAL 65 PSYCH. 0 TB 0
MEDICAL INSURANCE 88,469	GENERAL BEDS 3,601
	SKILLED NURSING FACILITIES 67
	BEDS 2,909
	HOME HEALTH AGENCIES 16
	INDEPENDENT LABORATORIES 6

AMOUNT REIMBURSED	ADMISSIONS & HOME HEALTH VISITS	
		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE $44,963,200	INPATIENT HOSPITAL ADMISSIONS 36,200	400.0
	SKILLED NURSING FACILITY ADMISSIONS 1,700	18.8
MEDICAL INSURANCE $18,581,300	HOME HEALTH VISITS 39,000	430.9

NEBRASKA

BENEFICIARIES	HEALTH CARE RESOURCES
HOSPITAL INSURANCE 214,546	HOSPITALS 125 GENERAL 119 PSYCH. 6 TB 0
MEDICAL INSURANCE 210,426	GENERAL BEDS 9,562
	SKILLED NURSING FACILITIES 20
	BEDS 1,380
	HOME HEALTH AGENCIES 17
	INDEPENDENT LABORATORIES 9

AMOUNT REIMBURSED	ADMISSIONS & HOME HEALTH VISITS	
		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE $118,365,300	INPATIENT HOSPITAL ADMISSIONS 90,600	422.3
	SKILLED NURSING FACILITY ADMISSIONS 3,000	14.0
MEDICAL INSURANCE $ 37,270,200	HOME HEALTH VISITS 66,000	307.6

NEVADA

BENEFICIARIES	HEALTH CARE RESOURCES
HOSPITAL INSURANCE 64,634	HOSPITALS 22 GENERAL 20 PSYCH. 2 TB 0
MEDICAL INSURANCE 62,786	GENERAL BEDS 2,686
	SKILLED NURSING FACILITIES 22
	BEDS 1,702
	HOME HEALTH AGENCIES 6
	INDEPENDENT LABORATORIES 20

AMOUNT REIMBURSED	ADMISSIONS & HOME HEALTH VISITS	
		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE $39,289,300	INPATIENT HOSPITAL ADMISSIONS 25,100	388.3
	SKILLED NURSING FACILITY ADMISSIONS 1,700	26.3
MEDICAL INSURANCE $21,461,100	HOME HEALTH VISITS 33,000	510.6

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APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79) Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

NEW HAMPSHIRE

BENEFICIARIES	HEALTH CARE RESOURCES
HOSPITAL INSURANCE 107,977	HOSPITALS 31 GENERAL 28 PSYCH. 3 TB 0
	GENERAL BEDS 3,255
MEDICAL INSURANCE 104,880	SKILLED NURSING FACILITIES 22
	BEDS 835
	HOME HEALTH AGENCIES 43
	INDEPENDENT LABORATORIES 8

AMOUNT REIMBURSED	ADMISSIONS & HOME HEALTH VISITS	PER 1000 BENEFICIARIES
HOSPITAL INSURANCE $57,880,500	INPATIENT HOSPITAL ADMISSIONS 36,400	337.1
	SKILLED NURSING FACILITY ADMISSIONS	24.1
MEDICAL INSURANCE $21,993,900	HOME HEALTH VISITS	926.1

NEW JERSEY

BENEFICIARIES	HEALTH CARE RESOURCES
HOSPITAL INSURANCE 903,293	HOSPITALS 127 GENERAL 116 PSYCH. 11 TB 0
	GENERAL BEDS 31,035
MEDICAL INSURANCE 893,515	SKILLED NURSING FACILITIES 122
	BEDS 13,950
	HOME HEALTH AGENCIES 45
	INDEPENDENT LABORATORIES 91

AMOUNT REIMBURSED	ADMISSIONS & HOME HEALTH VISITS	PER 1000 BENEFICIARIES
HOSPITAL INSURANCE $571,794,000	INPATIENT HOSPITAL ADMISSIONS 271,600	300.7
	SKILLED NURSING FACILITY ADMISSIONS 15,600	17.3
MEDICAL INSURANCE $267,936,000	HOME HEALTH VISITS 976,000	1080.5

NEW MEXICO

BENEFICIARIES	HEALTH CARE RESOURCES
HOSPITAL INSURANCE 119,579	HOSPITALS 50 GENERAL 48 PSYCH. 2 TB 0
	GENERAL BEDS 4,461
MEDICAL INSURANCE 116,667	SKILLED NURSING FACILITIES 4
	BEDS 223
	HOME HEALTH AGENCIES 14
	INDEPENDENT LABORATORIES 21

AMOUNT REIMBURSED	ADMISSIONS & HOME HEALTH VISITS	PER 1000 BENEFICIARIES
HOSPITAL INSURANCE $55,938,900	INPATIENT HOSPITAL ADMISSIONS 37,900	316.9
	SKILLED NURSING FACILITY ADMISSIONS 300	2.5
MEDICAL INSURANCE $27,743,300	HOME HEALTH VISITS 67,000	560.3

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APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79)
Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

NEW YORK

BENEFICIARIES		HEALTH CARE RESOURCES				
HOSPITAL INSURANCE	2,293,118	HOSPITALS	361	GENERAL 320	PSYCH. 41	TB 0
		GENERAL BEDS	80,447			
MEDICAL INSURANCE	2,260,487	SKILLED NURSING FACILITIES	520			
		BEDS	67,079			
		HOME HEALTH AGENCIES	120			
		INDEPENDENT LABORATORIES	209			

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$1,706,419,500	INPATIENT HOSPITAL ADMISSIONS	722,100	314.9
		SKILLED NURSING FACILITY ADMISSIONS	60,300	26.3
MEDICAL INSURANCE	$740,021,200	HOME HEALTH VISITS	1,488,000	648.9

NORTH CAROLINA

BENEFICIARIES		HEALTH CARE RESOURCES				
HOSPITAL INSURANCE	634,851	HOSPITALS	158	GENERAL 145	PSYCH. 13	TB 0
		GENERAL BEDS	23,603			
MEDICAL INSURANCE	626,482	SKILLED NURSING FACILITIES	134			
		BEDS	7,972			
		HOME HEALTH AGENCIES	80			
		INDEPENDENT LABORATORIES	16			

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$298,057,500	INPATIENT HOSPITAL ADMISSIONS	228,100	359.3
		SKILLED NURSING FACILITY ADMISSIONS	10,700	16.9
MEDICAL INSURANCE	$116,997,300	HOME HEALTH VISITS	325,000	511.9

NORTH DAKOTA

BENEFICIARIES		HEALTH CARE RESOURCES				
HOSPITAL INSURANCE	84,747	HOSPITALS	55	GENERAL 54	PSYCH. 1	TB 0
		GENERAL BEDS	4,068			
MEDICAL INSURANCE	83,095	SKILLED NURSING FACILITIES	57			
		BEDS	3,929			
		HOME HEALTH AGENCIES	11			
		INDEPENDENT LABORATORIES	12			

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$52,892,500	INPATIENT HOSPITAL ADMISSIONS	41,400	488.5
		SKILLED NURSING FACILITY ADMISSIONS	1,600	18.9
MEDICAL INSURANCE	$18,957,500	HOME HEALTH VISITS	19,000	224.2

* Amount Reimbursed represents amounts paid in calendar year 1978 to, or on behalf of, insured persons.

APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79) Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

OHIO

BENEFICIARIES	
HOSPITAL INSURANCE	1,250,479
MEDICAL INSURANCE	1,222,751

HEALTH CARE RESOURCES					
HOSPITALS	228	GENERAL	208	PSYCH. 19	TB 1
GENERAL BEDS	50,215				
SKILLED NURSING FACILITIES	245				
BEDS	24,192				
HOME HEALTH AGENCIES	110				
INDEPENDENT LABORATORIES	123				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$796,518,400
MEDICAL INSURANCE	$246,115,900

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	431,200	344.8
SKILLED NURSING FACILITY ADMISSIONS	29,100	23.3
HOME HEALTH VISITS	602,000	481.4

OKLAHOMA

BENEFICIARIES	
HOSPITAL INSURANCE	386,868
MEDICAL INSURANCE	380,629

HEALTH CARE RESOURCES					
HOSPITALS	137	GENERAL	131	PSYCH. 5	TB 1
GENERAL BEDS	14,207				
SKILLED NURSING FACILITIES	7				
BEDS	353				
HOME HEALTH AGENCIES	61				
INDEPENDENT LABORATORIES	56				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$211,160,600
MEDICAL INSURANCE	$79,865,400

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	150,600	389.3
SKILLED NURSING FACILITY ADMISSIONS	1,800	4.7
HOME HEALTH VISITS	62,000	160.3

OREGON

BENEFICIARIES	
HOSPITAL INSURANCE	317,045
MEDICAL INSURANCE	304,041

HEALTH CARE RESOURCES					
HOSPITALS	81	GENERAL	77	PSYCH. 4	TB 0
GENERAL BEDS	8,733				
SKILLED NURSING FACILITIES	53				
BEDS	3,632				
HOME HEALTH AGENCIES	32				
INDEPENDENT LABORATORIES	38				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$181,373,100
MEDICAL INSURANCE	$ 69,192,200

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	101,300	319.5
SKILLED NURSING FACILITY ADMISSIONS	5,700	18.(
HOME HEALTH VISITS	147,000	463.7

* Amount Reimbursed represents amounts paid in calendar year 1978 to, or on behalf of, insured persons.

APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79) Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

PENNSYLVANIA

BENEFICIARIES	
HOSPITAL INSURANCE	1,613,664
MEDICAL INSURANCE	1,582,293

HEALTH CARE RESOURCES					
HOSPITALS	278	GENERAL	248	PSYCH. 30	TB 0
GENERAL BEDS	53,581				
SKILLED NURSING FACILITIES	288				
BEDS	29,917				
HOME HEALTH AGENCIES	115				
INDEPENDENT LABORATORIES	158				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$982,383,500
MEDICAL INSURANCE	$399,704,300

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	537,200	332.9
SKILLED NURSING FACILITY ADMISSIONS	34,300	21.3
HOME HEALTH VISITS	1,532,000	949.4

RHODE ISLAND

BENEFICIARIES	
HOSPITAL INSURANCE	133,145
MEDICAL INSURANCE	130,579

HEALTH CARE RESOURCES					
HOSPITALS	19	GENERAL	16	PSYCH. 3	TB 0
GENERAL BEDS	4,561				
SKILLED NURSING FACILITIES	40				
BEDS	1,801				
HOME HEALTH AGENCIES	13				
INDEPENDENT LABORATORIES	28				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$86,548,800
MEDICAL INSURANCE	$41,337,600

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	41,101	308.7
SKILLED NURSING FACILITY ADMISSIONS	5,500	41.3
HOME HEALTH VISITS	121,000	908.8

SOUTH CAROLINA

BENEFICIARIES	
HOSPITAL INSURANCE	305,698
MEDICAL INSURANCE	300,646

HEALTH CARE RESOURCES					
HOSPITALS	79	GENERAL	74	PSYCH. 4	TB 1
GENERAL BEDS	10,956				
SKILLED NURSING FACILITIES	79				
BEDS	6,068				
HOME HEALTH AGENCIES	20				
INDEPENDENT LABORATORIES	15				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$128,326,500
MEDICAL INSURANCE	$ 52,210,100

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	97,300	318.3
SKILLED NURSING FACILITY ADMISSIONS	4,900	16.0
HOME HEALTH VISITS	172,000	562.6

* Amount Reimbursed represents amounts paid in calendar year 1978 to, or on behalf of, insured persons.

APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79) Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

SOUTH DAKOTA

BENEFICIARIES	
HOSPITAL INSURANCE	96,000
MEDICAL INSURANCE	93,886

HEALTH CARE RESOURCES					
HOSPITALS	65	GENERAL	65	PSYCH. 0	TB 0
GENERAL BEDS	3,892				
SKILLED NURSING FACILITIES	7				
BEDS	393				
HOME HEALTH AGENCIES	30				
INDEPENDENT LABORATORIES	7				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$48,454,200
MEDICAL INSURANCE	$14,269,600

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	40,500	421.9
SKILLED NURSING FACILITY ADMISSIONS	900	9.4
HOME HEALTH VISITS	25,000	260.4

TENNESSEE

BENEFICIARIES	
HOSPITAL INSURANCE	546,939
MEDICAL INSURANCE	542,852

HEALTH CARE RESOURCES					
HOSPITALS	160	GENERAL	152	PSYCH. 7	TB 1
GENERAL BEDS	24,269				
SKILLED NURSING FACILITIES	52				
BEDS	2,640				
HOME HEALTH AGENCIES	140				
INDEPENDENT LABORATORIES	35				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$262,206,500
MEDICAL INSURANCE	$101,379,400

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	237,400	434.1
SKILLED NURSING FACILITY ADMISSIONS	4,600	8.4
HOME HEALTH VISITS	328,000	599.7

TEXAS

BENEFICIARIES	
HOSPITAL INSURANCE	1,378,168
MEDICAL INSURANCE	1,366,176

HEALTH CARE RESOURCES					
HOSPITALS	526	GENERAL	503	PSYCH. 20	TB 3
GENERAL BEDS	61,096				
SKILLED NURSING FACILITIES	65				
BEDS	2,402				
HOME HEALTH AGENCIES	87				
INDEPENDENT LABORATORIES	206				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$772,745,800
MEDICAL INSURANCE	$366,201,600

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	582,900	423.0
SKILLED NURSING FACILITY ADMISSIONS	6,500	4.7
HOME HEALTH VISITS	748,000	542.7

* Amount Reimbursed represents amounts paid in calendar year 1978 to, or on behalf of, insured persons.

APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79) Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

UTAH

BENEFICIARIES	
HOSPITAL INSURANCE	111,586
MEDICAL INSURANCE	106,153

HEALTH CARE RESOURCES					
HOSPITALS	42	GENERAL	41	PSYCH. 1	TB 0
GENERAL BEDS	4,017				
SKILLED NURSING FACILITIES	24				
BEDS	1,841				
HOME HEALTH AGENCIES	9				
INDEPENDENT LABORATORIES	16				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$50,277,900
MEDICAL INSURANCE	$22,669,600

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	34,900	312.8
SKILLED NURSING FACILITY ADMISSIONS	2,300	20.6
HOME HEALTH VISITS	47,000	421.2

VERMONT

BENEFICIARIES	
HOSPITAL INSURANCE	62,588
MEDICAL INSURANCE	61,684

HEALTH CARE RESOURCES					
HOSPITALS	20	GENERAL	18	PSYCH. 2	TB 0
GENERAL BEDS	2,140				
SKILLED NURSING FACILITIES	19				
BEDS	698				
HOME HEALTH AGENCIES	19				
INDEPENDENT LABORATORIES	3				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$34,097,900
MEDICAL INSURANCE	$13,122,100

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	22,800	364.3
SKILLED NURSING FACILITY ADMISSIONS	1,400	22.4
HOME HEALTH VISITS	101,000	1,613.7

VIRGINIA

BENEFICIARIES	
HOSPITAL INSURANCE	525,271
MEDICAL INSURANCE	510,519

HEALTH CARE RESOURCES					
HOSPITALS	127	GENERAL	112	PSYCH. 14	TB 1
GENERAL BEDS	22,555				
SKILLED NURSING FACILITIES	50				
BEDS	1,765				
HOME HEALTH AGENCIES	46				
INDEPENDENT LABORATORIES	32				

AMOUNT REIMBURSED	
HOSPITAL INSURANCE	$273,882,000
MEDICAL INSURANCE	$115,821,800

ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
INPATIENT HOSPITAL ADMISSIONS	182,100	346.7
SKILLED NURSING FACILITY ADMISSIONS	3,700	7.0
HOME HEALTH VISITS	128,000	243.7

* Amount Reimbursed represents amounts paid in calendar year 1978 to, or on behalf of, insured persons.

APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79)
Amount Reimbursed*, Admissions and Home Health Visits(calendar year 1978)

WASHINGTON

BENEFICIARIES		HEALTH CARE RESOURCES				
HOSPITAL INSURANCE	445,624	HOSPITALS 114	GENERAL 108	PSYCH. 5	TB 1	
MEDICAL INSURANCE	434,924	GENERAL BEDS 11,834				
		SKILLED NURSING FACILITIES 90				
		BEDS 10,167				
		HOME HEALTH AGENCIES 28				
		INDEPENDENT LABORATORIES 76				

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		
				PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$225,414,400	INPATIENT HOSPITAL ADMISSIONS	145,100	325.6
		SKILLED NURSING FACILITY ADMISSIONS	9,300	20.9
MEDICAL INSURANCE	$ 97,325,900	HOME HEALTH VISITS	196,000	439.8

WEST VIRGINIA

BENEFICIARIES		HEALTH CARE RESOURCES				
HOSPITAL INSURANCE	265,928	HOSPITALS 73	GENERAL 70	PSYCH. 3	TB 0	
		GENERAL BEDS 10,374				
MEDICAL INSURANCE	261,873	SKILLED NURSING FACILITIES 34				
		BEDS 2,703				
		HOME HEALTH AGENCIES 27				
		INDEPENDENT LABORATORIES 21				

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		
				PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$125,324,300	INPATIENT HOSPITAL ADMISSIONS	102,800	386.6
		SKILLED NURSING FACILITY ADMISSIONS	3,400	12.8
MEDICAL INSURANCE	$ 38,667,300	HOME HEALTH VISITS	113,000	424.9

WISCONSIN

BENEFICIARIES		HEALTH CARE RESOURCES				
HOSPITAL INSURANCE	596,104	HOSPITALS 164	GENERAL 148	PSYCH. 16	TB 0	
		GENERAL BEDS 21,381				
MEDICAL INSURANCE	588,759	SKILLED NURSING FACILITIES 76				
		BEDS 5,732				
		HOME HEALTH AGENCIES 83				
		INDEPENDENT LABORATORIES 22				

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		
				PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$374,638,100	INPATIENT HOSPITAL ADMISSIONS	206,600	346.6
		SKILLED NURSING FACILITY ADMISSIONS	5,100	8.6
MEDICAL INSURANCE	128,679,300	HOME HEALTH VISITS	271,000	454.6

* Amount Reimbursed represents amounts paid in calendar year 1978 to, or on behalf of, insured persons.

APPENDIX C

Beneficiaries (as of 1/1/79) Participating Health Care Resources (as of 7/1/79) Amount Reimbursed*, Admissions and Home Health Visits (calendar year 1978)

WYOMING

BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	39,309	HOSPITALS 29 GENERAL 28 PSYCH. 1 TB 0
MEDICAL INSURANCE	37,994	GENERAL BEDS 1,685
		SKILLED NURSING FACILITIES 2
		BEDS 273
		HOME HEALTH AGENCIES 14
		INDEPENDENT LABORATORIES 4

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$18,329,700	INPATIENT HOSPITAL ADMISSIONS	13,200	335.8
MEDICAL INSURANCE	$ 7,217,200	SKILLED NURSING FACILITY ADMISSIONS	100	2.5
		HOME HEALTH VISITS	28,000	712.3

PUERTO RICO

BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	327,145	HOSPITALS 56 GENERAL 55 PSYCH. 1 TB 0
MEDICAL INSURANCE	174,709	GENERAL BEDS 8,211
		SKILLED NURSING FACILITIES 4
		BEDS 186
		HOME HEALTH AGENCIES 28
		INDEPENDENT LABORATORIES 35

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$49,884,300	INPATIENT HOSPITAL ADMISSIONS	63,500	194.1
MEDICAL INSURANCE	$31,400,600	SKILLED NURSING FACILITY ADMISSIONS	500	1.5
		HOME HEALTH VISITS	436,000	1,332.7

OTHER AREAS

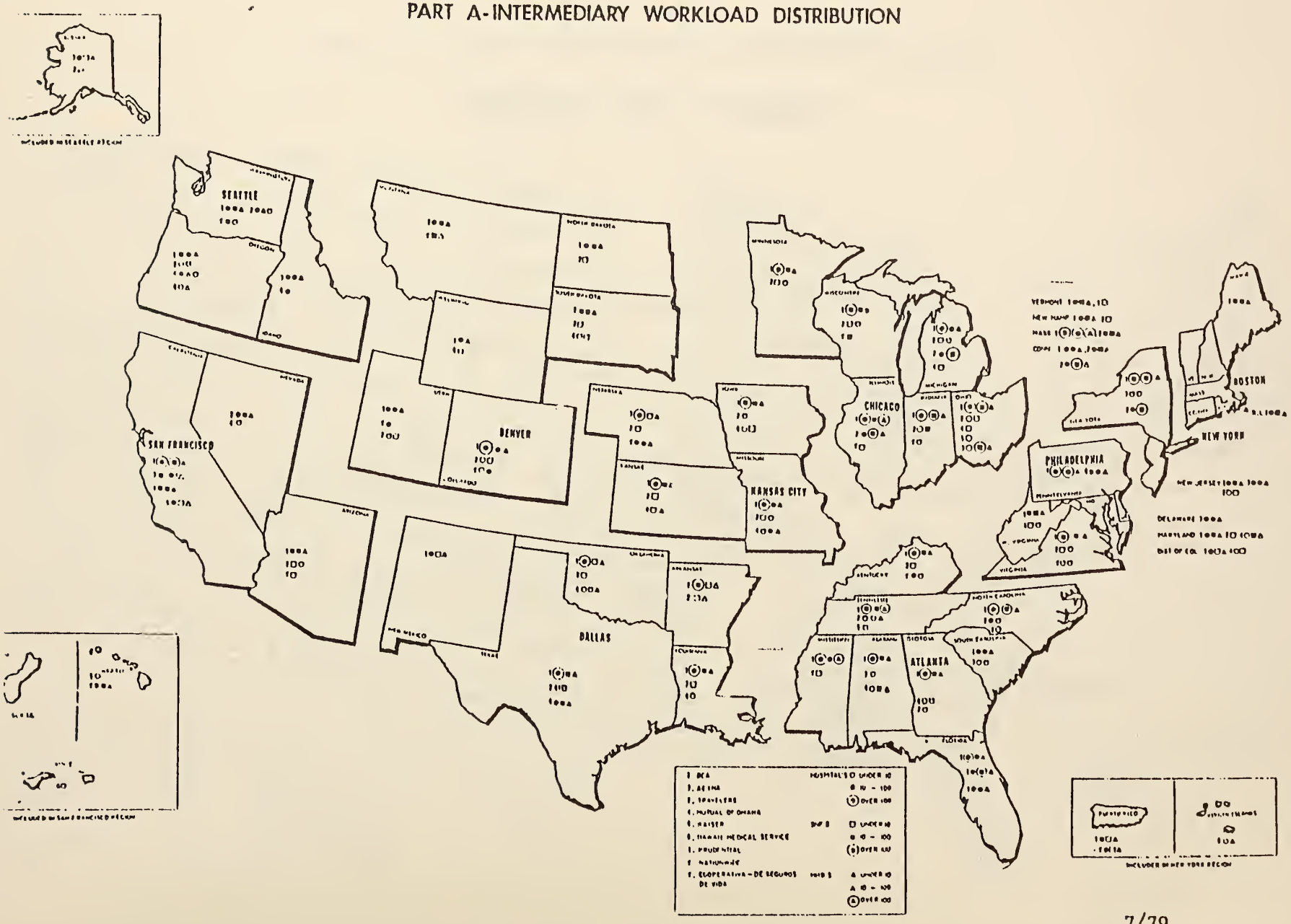
BENEFICIARIES		HEALTH CARE RESOURCES
HOSPITAL INSURANCE	$256,979	HOSPITALS 4 GENERAL 4 PSYCH. 0 TB 0
MEDICAL INSURANCE	71,306	GENERAL BEDS 614
		SKILLED NURSING FACILITIES 1
		BEDS 16
		HOME HEALTH AGENCIES 2
		INDEPENDENT LABORATORIES 4

AMOUNT REIMBURSED		ADMISSIONS & HOME HEALTH VISITS		PER 1000 BENEFICIARIES
HOSPITAL INSURANCE	$11,278,670	INPATIENT HOSPITAL ADMISSIONS	1,800	7.0
MEDICAL INSURANCE	9,676,000	SKILLED NURSING FACILITY ADMISSIONS	13	0.1
		HOME HEALTH VISITS	6,000	23.3

* Amount Reimbursed represents amounts paid in calendar year 1978 to, or on behalf of, insured persons.

HEALTH CARE FINANCING ADMINISTRATION

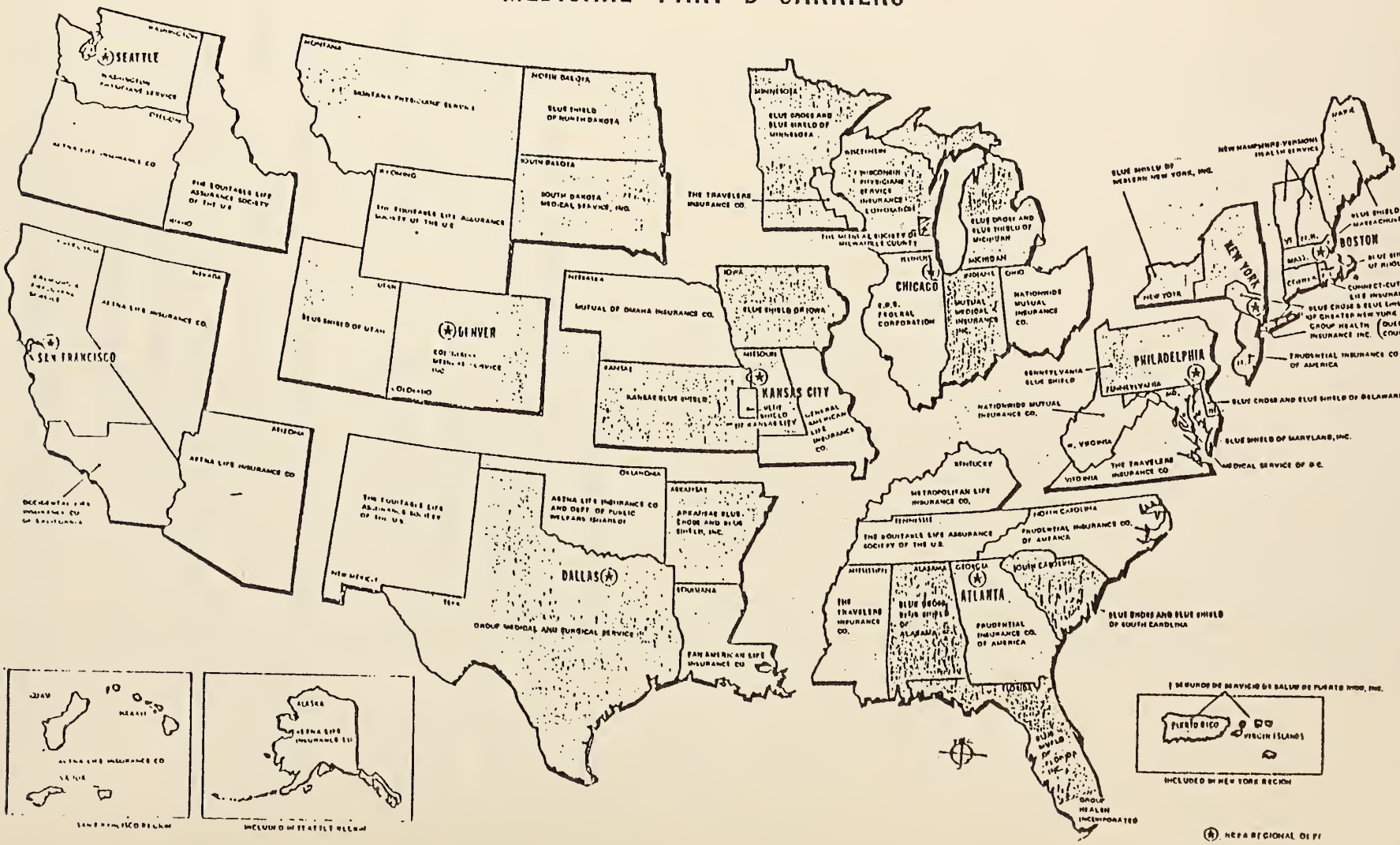
PART A-INTERMEDIARY WORKLOAD DISTRIBUTION



7/79

HEALTH CARE FINANCING ADMINISTRATION

'MEDICARE' PART B CARRIERS



Appendix F -- Five-Year Trend Analysis of Contractor Administrative Costs and Productivity Improvements

PART A INTERMEDIARIES

FY 1975 Through FY 1979

The following tables contain significant workload, administrative cost, average manpower, and benefit payment data reflecting the combined performance of all Part A intermediaries from fiscal year 1975 through 1979.

During the period, the annual workloads rose a total of 41.5 percent over the base while total administrative costs rose only 32.8 percent. In terms of total unit cost, the decrease from $5.90 to $5.54 is 6.1 percent. These decreased costs reflect the expanded use of automatic data processing equipment and improved procedures.

PART A INTERMEDIARIES
TREND DATA AND INDICES
WORKLOAD AND COST

Fiscal Year	Bills Processed	Total Adm. Cost	Total Unit Cost	Adm. Cost 1/	Unit Cost Exc. Audit 1/	Provider Audit and Reimbursement
1975	25,723,354	$151,760,800	$5.90	$121,527,200	$4.72	$36,791,800
1976	28,898,668	164,844,800	5.70	132,989,300	4.60	39,656,700
1977	32,119,004	182,331,000	5.68	146,848,500	4.57	44,146,800
1978	34,862,437	191,259,600	5.49	141,824,000	4.07	47,695,400
1979	36,410,138	201,546,200	5.54	147,411,000	4.05	51,980,900
			INDICES (FY 1975 as 100%)			
1975	100.0	100.0	100.0	100.0	100.0	100.0
1976	112.3	108.6	96.6	109.4	97.5	107.8
1977	124.1	120.1	96.3	120.8	96.8	120.0
1978	135.5	126.0	93.1	116.7	86.2	129.6
1979	141.5	132.8	93.9	121.3	85.8	141.3

1/ For FY 1975 excludes Provider Audit Cost
For FY 1976 and 1977 excludes Provider Audit, PSRO and HMO costs
For FY 1978 and 1979 excludes Provider Reimbursement, Provider Audit, PSRO and HMO costs

PART A INTERMEDIARIES
TREND DATA AND INDICES
PRODUCTIVITY, PERSONAL SERVICE COSTS AND BENEFITS

Fiscal Year 1/	Man-Years	Production Per Man-Year	Avg. P.S. Cost Per Man-Year	Benefits Paid (M)	Benefits Paid Per Bill	% of Adm. Cost to Bene. (Inc. Audit)
1975	7,517.1	3,422	$10,989	$10,711,900	$416.43	1.4
1976	7,606.9	3,799	12,119	12,855,000	444.83	1.3
1977	7,607.9	4,222	13,474	15,846,400	493.37	1.2
1978	6,895.1	5,056	14,415	18,405,100	527.93	1.0
1979	6,681.0	5,450	15,623	20,931,400	574.88	1.0
			INDICES (FY 1975 as 100%)			
1975	100.0	100.0	100.0	100.0	100.0	100.0
1976	101.2	111.0	110.3	120.0	106.8	92.9
1977	101.2	123.4	122.6	147.9	118.5	85.7
1978	91.7	147.7	131.2	171.8	126.8	71.4
1979	88.9	159.3	142.1	195.4	138.0	71.4

1/ For FY 1975 data excludes Provider Audit activities
For FY 1976 and 1977 data excludes Provider Audit, PSRO and HMO activities
For FY 1978 and 1979 data excludes Provider Reimbursement, Provider Audit, PSRO and HMO activities

PART B CARRIERS

FY 1975 Through FY 1979

The following tables contain significant workload, administrative cost, average manpower, and benefit payment data reflecting the combined performance of all Part B carriers from fiscal year 1975 through 1979

During the period, the annual workloads rose a total of 65.6 percent over the base while total administrative costs rose only 45.0 percent. In terms of unit cost for processing claims, the decrease from $3.21 to $2.81 is 12.5 percent. Contributing to the reduced cost of processing a claim, in addition to expanded use of data processing equipment and improved procedures, are the increased use of facilities management subcontracts and fixed price contracts which limited the manpower increase to 4.3 percent over FY 1975 manpower levels.

PART B CARRIERS
TREND DATA AND INDICES
WORKLOAD AND COST

Fiscal Year	Claims Processed	Adm. Cost	Claims Unit Cost	Payment Records Processed	Payment Records Unit Cost
1975	80,613,749	$258,748,100	$3.21	63,837,400	$4.05
1976	92,399,466	290,241,800	3.14	75,266,100	3.86
1977	108,126,297	322,608,800	2.98	88,983,800	3.63
1978	120,439,707	344,572,700	2.86	100,087,300	3.43
1979	133,494,858	375,273,500	2.81	112,864,600	3.32
		INDICES (FY 1975 as 100%)			
1975	100.0	100.0	100.0	100.0	100.0
1976	114.6	112.2	97.8	117.9	95.3
1977	134.1	124.7	92.8	139.4	89.6
1978	149.4	133.2	89.1	156.8	84.7
1979	165.6	145.0	87.5	176.8	82.0

PART B CARRIERS
TREND DATA AND INDICES
PRODUCTIVITY, PERSONAL SERVICE COSTS AND BENEFITS
(EXCLUDING PSRO & HMO)

Fiscal Year	Man-Years	Production Per Man-Year	Avg. P.S. Cost Per Man-Year	Benefits Paid (M)	Benefits Paid Per Claim	% of Adm. Cost to Benefits
1975	15,802.0	5,101	$ 9,675	$3,070,630	$38.09	8.4
1976	16,688.9	5,537	10,553	3,658,974	39.60	7.9
1977	16,995.8	6,357	11,777	4,634,568	42.86	7.0
1978	16,851.8	7,110	12,770	5,436,781	45.14	6.3
1979	16,474.0	8,103	13,753	6,360,068	47.64	5.9
			INDICES (FY 1975 as 100%)			
1975	100.0	100.0	100.0	100.0	100.0	100.0
1976	105.6	108.5	109.1	119.2	104.0	94.0
1977	107.6	124.6	121.7	150.9	112.5	83.3
1978	106.6	139.4	132.0	177.1	118.5	75.0
1979	104.3	158.9	142.1	207.1	125.1	70.2